Uniform Business Office

OUTPATIENT ITEMIZED BILLING TRAINING COURSE

2002 FUNCTIONAL TRAINING

Agenda

OUTPATIENT ITEMIZED BILLING TRAINING COURSE

Day One

Morning

Welcome and Introductions

Tab 1: Outpatient Itemized Billing Training Agenda

Tab 2: Outpatient Itemized Billing Overview

Tab 3: Procedure Coding and System Automation

Afternoon

Tab 4: Evaluation and Management (E/M)

Tab 5: Use of Modifiers

Tab 6: CMS-1500 Claim Form

Tab 7: CMS-1450/UB-92 Claim Form

Day Two

Morning

Tab 8: Pharmacy

Tab 9: Universal Claim Form (UCF)

Tab 10: MSA and MAC

Tab 11: Supporting Documentation and Coding for Accurate Billing

Tab 12: Compliance "Always On Your Mind"

Afternoon

Tab 13: Collecting OHI Documentation

Tab 14: MTF and Payer Concerns

Tab 15: Department of Veterans Affairs Lessons Learned

Day Three

Tab 16: Keys to Change

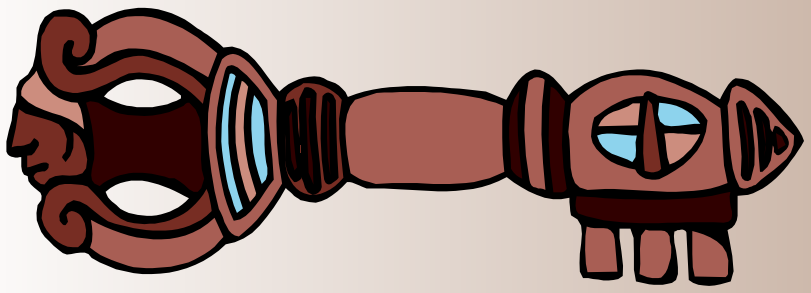
Tab 17: Keys to Training

Tab 18: Keys to Implementing OIB at your MTF

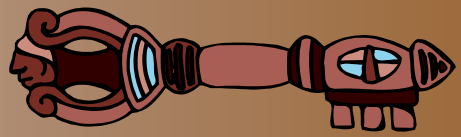
TRAINING MATERIAL DISCLAIMER

Standard Technology, Inc., allows DoD organizations and individuals to reproduce/print proprietary materials for in-house educational use only. The photocopies or reproductions are not to be "used for any purpose other than private or group study." Copied materials must include the full proprietary citation on each page.

TRAINING COURSE OVERVIEW



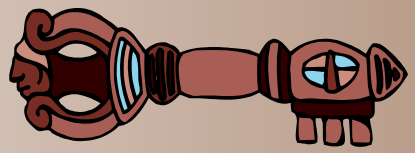
Objectives



- Review the evolution of the Outpatient Itemized Billing implementation
- Provide purpose of Outpatient Itemized Billing Training Course
- Discuss functional training goals and objectives
- Discuss “parking permits”
- Review OIB Training Course agenda and manual
- Discuss Team Agreement

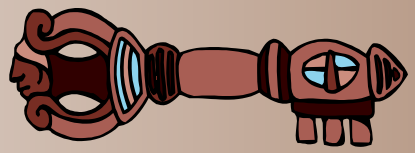
Evolution of Outpatient Itemized Billing

- **OIB methodology development involved MTF and DoD representatives**
- **Business rules developed in CY 00 to CY 02**
  - System change requests were drafted based on business rules for changes to CHCS, ADM and TPOCS
  - Involved many work group meetings for system and functional issues
- **National Defense Authorization Act FY 01 authorized MTFs to move from "reasonable costs" to "reasonable charges"**



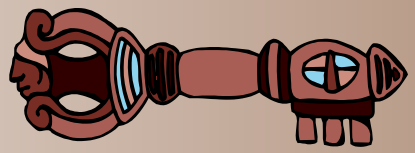
Evolution of Outpatient Itemized Billing

- **Billing/Coding training needs assessment survey was developed in January 01**
- **Training materials were developed and a pilot class was presented in August 01**
- **OIB concepts were presented at UBO Conference in CY 00 and CY 01**
- **OIB concepts also presented at TRICARE CY 01 and CY 02**



Purposes of OIB Training Course

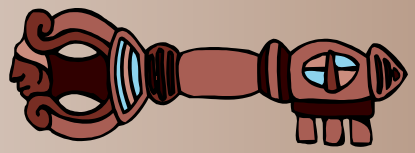
- **Provide education to MTF staff for the transition to Outpatient Itemized Billing**
- **Foster an environment for active learning and networking**



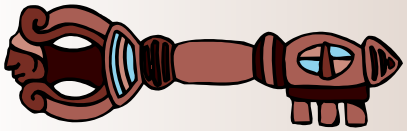
Functional Training Objectives

Using the "Train the Trainer" concept, functional training will:

- Provide a thorough understanding of Outpatient Itemized Billing concepts, policies, procedures and guidelines that apply to the Uniform Business Office
- Provide a basic overview of coding principles and applications as they pertain to OIB
- Provide instructions for completing the UB-92, CMS-1500, UCF, DD7A and I&R claim/billing forms as they apply to OIB
- Provide tools to help with the implementation of OIB

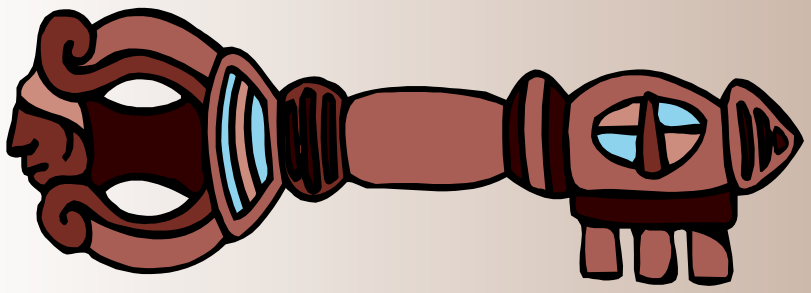


Parking Lot Ground Rules

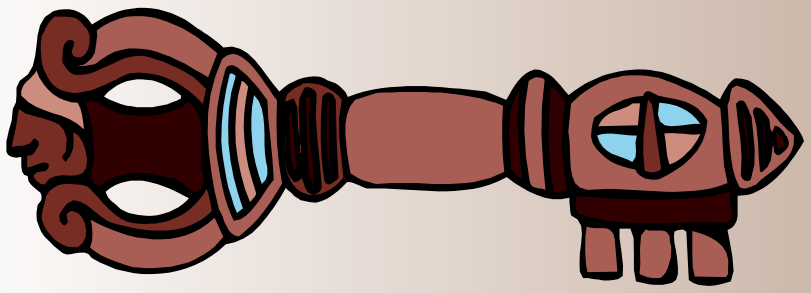


- The parking lot is a placeholder for questions that cannot be readily answered
- Participants should hold their questions until the end of each presentation
- For questions that require further research or pertain to systems, participants should place those on the provided “parking permits”
- All parking lot questions will be researched and responded to in a timely manner
- Trainers will collect parking permits at the end of each day

Training Course Agenda



Training Course Manual



Team Agreement

- **Give 100% of yourself this week**
- **Allow trainers to respond to questions first**
- **We have a lot to cover each day; please be prompt**
- **Hold all questions until after each presentation**

Uniform Business Office
Outpatient Itemized Billing Training Course

OUTPATIENT ITEMIZED BILLING OVERVIEW

Objectives

- Discuss driving forces for Outpatient Itemized Billing implementation
- Discuss OIB concepts and process
- Explain data sources
- Discuss TPC and MSA overview
- Explain calculating rates
- Discuss impact on DoD and Payers

Driving Force

- Desire to align Outpatient Itemized Billing methodology with the civilian sector
- Lack of itemized charges prevents electronic billing of the CMS-1500
- CFR published FY 2001 sunset clause contingent on transition to itemized billing
- Improve Outpatient encounter coding and documentation
- Ensure billing accountability and compliance
- Standardization of SIT/OHI to support health insurance portability throughout the Military Health System

OIB Concepts

- **Moving away from all-inclusive outpatient charges to itemized charges which includes:**
  - Services/procedures received in count/non-count visits Standard Ambulatory Data Record (SADR)
  - Visits documented with E/M codes
  - Ancillaries-laboratory, radiology, pharmacy (CHCS feed)
- **Modifiers will be incorporated to further define certain services/procedures**
- **OHI will be captured in CHCS and drives the bill**
  - Now there's more of an emphasis on the revenue cycle and the capture of OHI at the front end

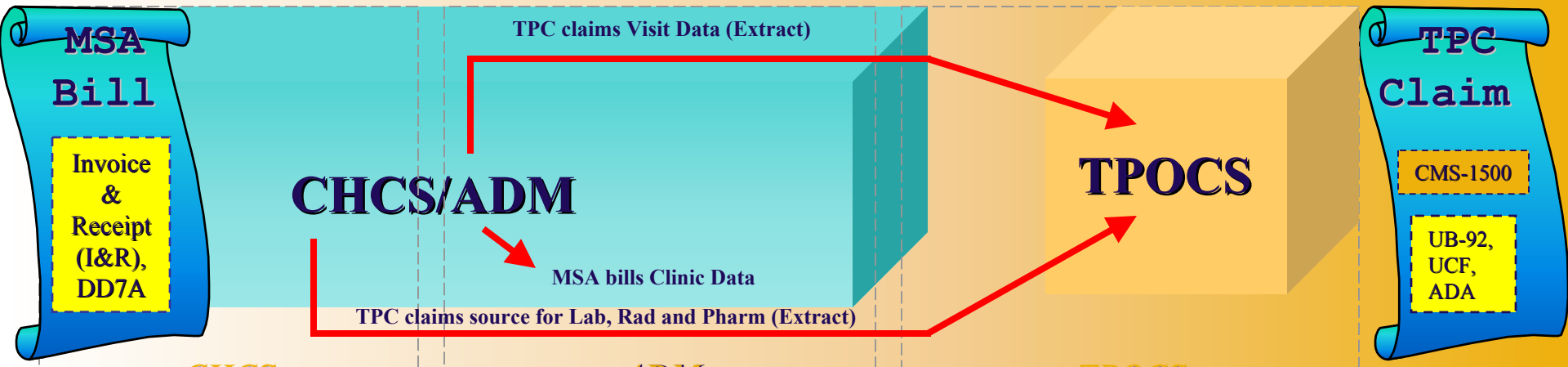
OIB Process

- **Itemized charges will be reflected on the following claim forms within Third Party Outpatient Collection System (TPOCS):**
  - CMS-1500
  - UB-92
  - American Dental Association (ADA)
  - Universal Claim Form (UCF)
- **Itemized charges in Outpatient MSA will be produced on the I&R and DD7A forms**
- **No changes for inpatient charges will occur in this first phase of implementation**

Data Sources

- **CHCS: Composite Health Care System**
- **ADM : Ambulatory Data Module (formerly KG-ADS, now a module within CHCS)**
- **TPOCS: Third Party Outpatient Collection System**

Systems Outpatient Information Flow



CHCS
Shares common files

- Collect Appointment Data
- Collects Registration Data
- Collects OHI, utilizes SIT
- Collects Order Entry and Ancillary Services data (Laboratory, Radiology, Pharmacy)
- Collects Provider Information
- Provides lab, rad and pharm data for TPC & MSA

ADM
Completes Clinical Data

- Validates,Appointment, Provider, Patient data
- Tracks events occurring in clinic (diagnostics, procedures, services, ancillaries, etc.)
- Attaches Secondary Providers and Outpatient encounter information.
- Disposition Type
- Captures Condition at Disposition
- Builds encounter record
- Source system
- Provides visit data for TPC & MSA

TPOCS
Provides Billing Data

- Creates Bill
- Attaches Revenue Codes
- Attaches Provider Information
- Attaches Patient Information
- Attaches Diagnostic Information
- Attaches Procedure Information
- Attaches Units of Service
- Attaches Rates/Costs
- Accepts manually-entered encounter information for billing

TPC Claim Forms

Clinic Visit

Ancillary Clinic Visit
(Lab, Rad, Pharm)

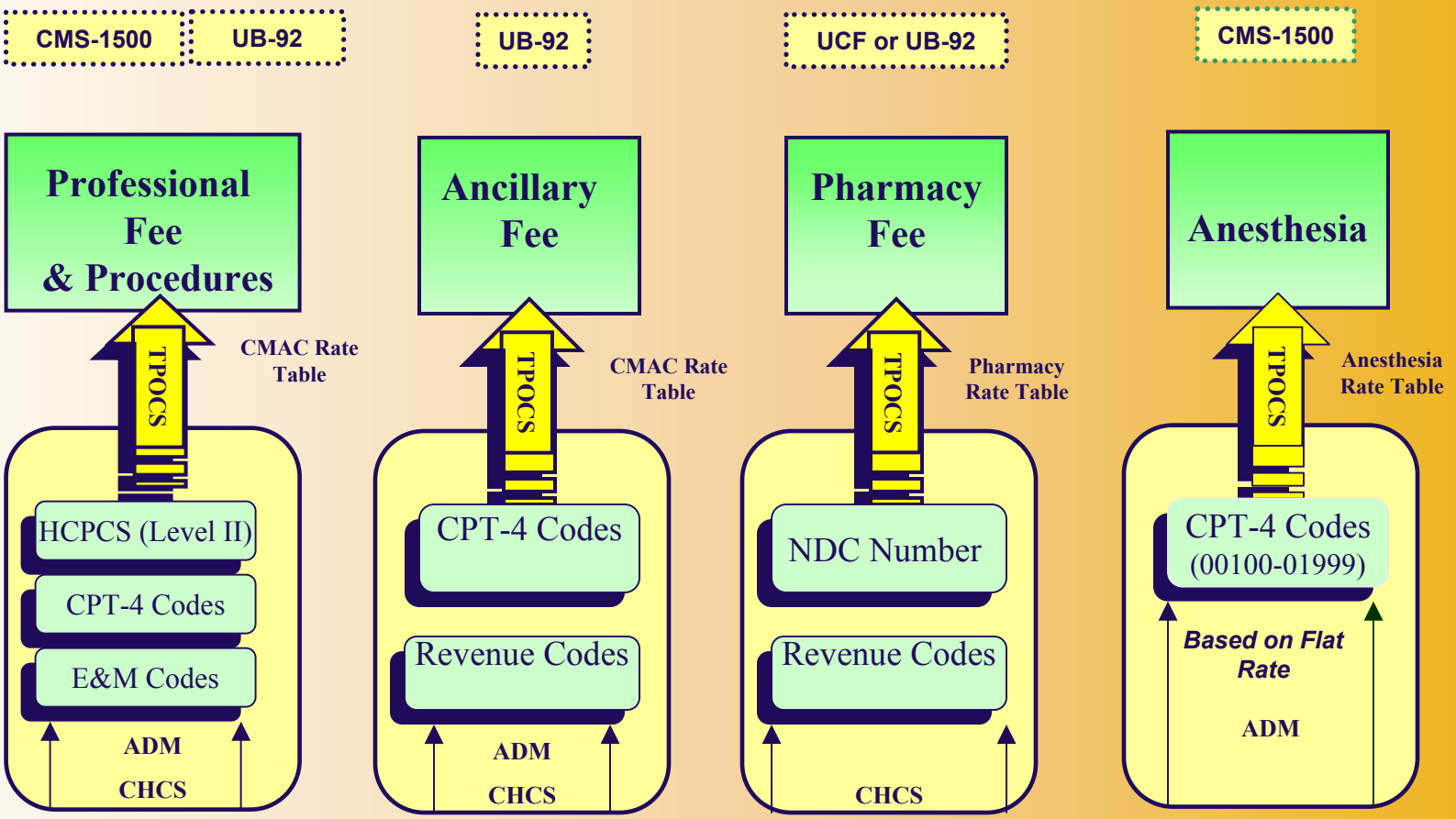
UB-92
Clinic Services
Supplies

CMS-1500
Professional Services
Anesthesia
E/M Codes

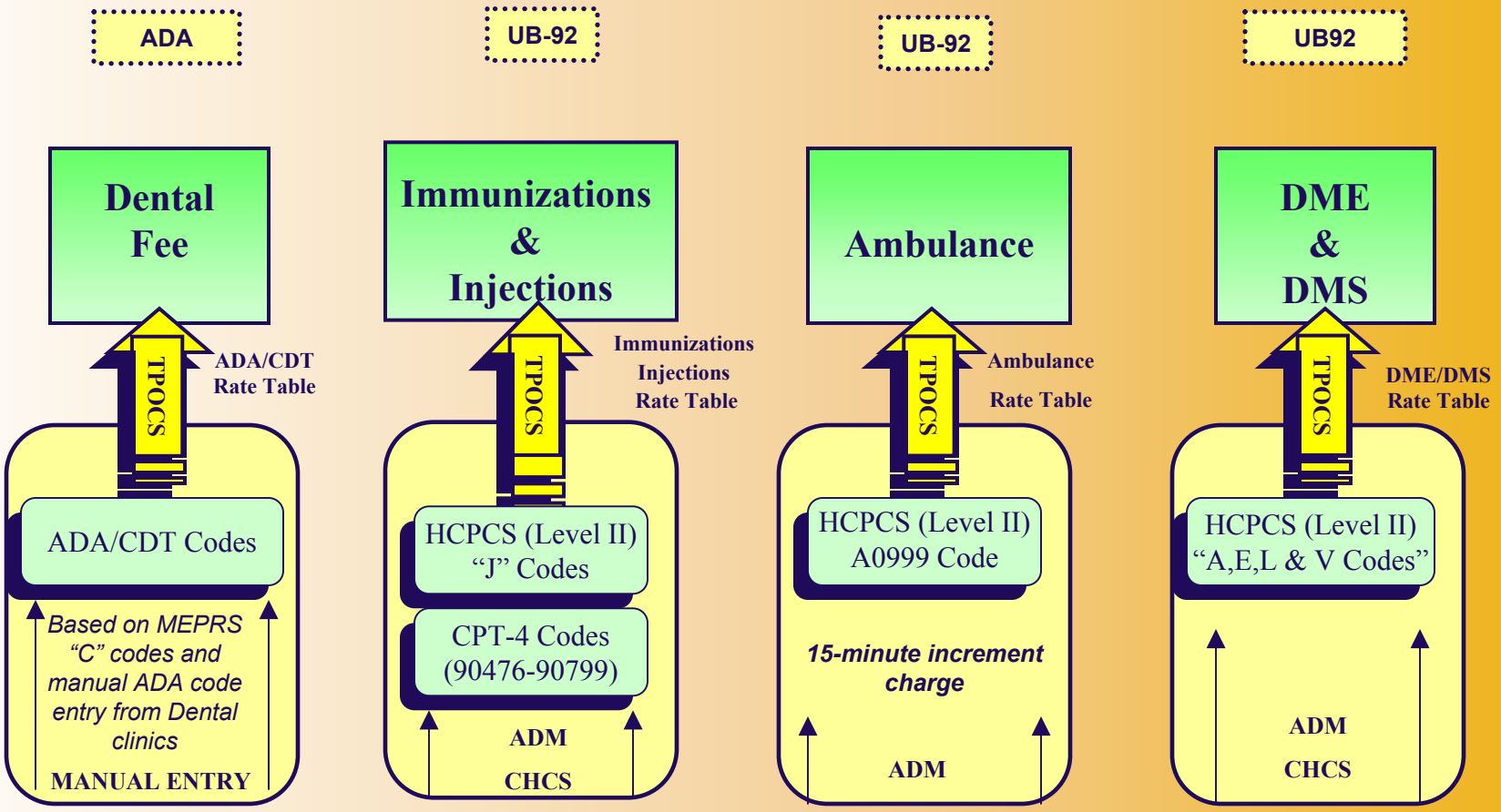
UB-92
Ancillary Services
for Lab and Rad
not performed in clinic

UCF or UB-92
Pharmacy

TPC Outpatient Itemized Billing Methodology



TPC Outpatient Itemized Billing Methodology



MSA Billing Forms

Clinic Visit

I&R/DD7A
Clinic Services/Professional Services/Supplies

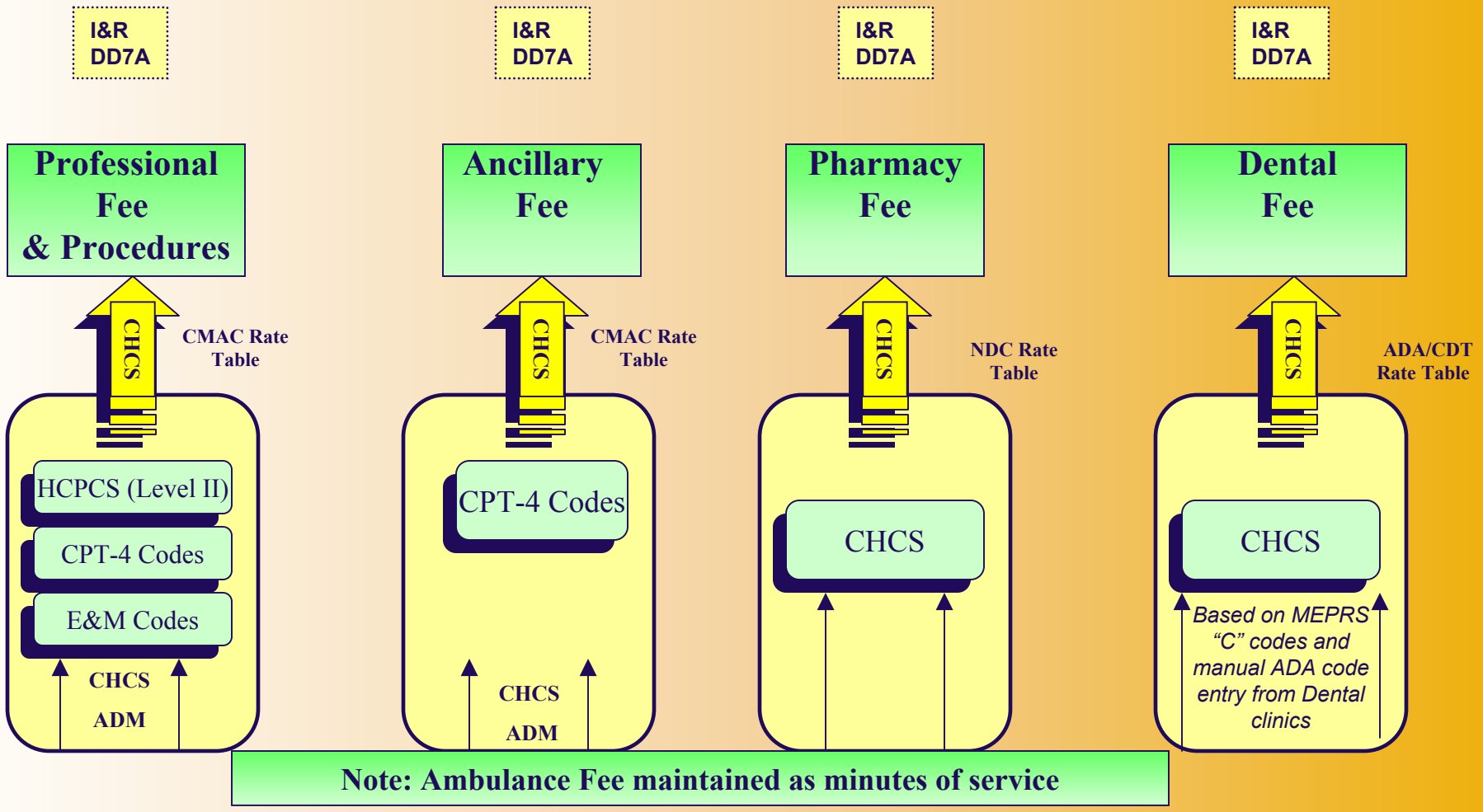
Itemized Charges listed on I&R, consolidated for DD7A

Ancillary Clinic Visit (Lab, Rad, Pharm)

I&R/DD7A
Ancillary Services for Lab and Rad not performed in clinic

I&R/DD7A
Pharmacy

MSA Itemized Billing Methodology



Calculating Rates

- **The systems (both CHCS and TPOCS) will contain the following rate tables:**
  - CMAC
    - Non-CMAC
    - Component
  - Anesthesia
  - DME/DMS
  - Pharmacy
  - Dental
  - Ambulance
  - Immunizations/Injections
- **All rate tables (except for pharmacy) will be updated yearly**

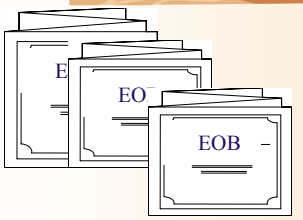
THE KEYS TO OUTPATIENT ITEMIZED BILLING

The MTF Revenue Cycle

MTF

H. Close Account

Accounts RECEIVABLE



A. Scheduling

Patient Access
a. Appointment Scheduling
b. Pre-Registration
c. Walk-in

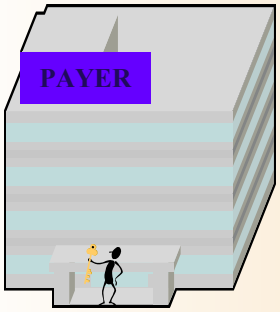
Verification
a. Insurance Confirmation
b. Insurance Verification
c. Pre-Cert Requirements

B. Verification

Billing/Collections
a. Claims Submission
b. Follow-up
c. Claims Status

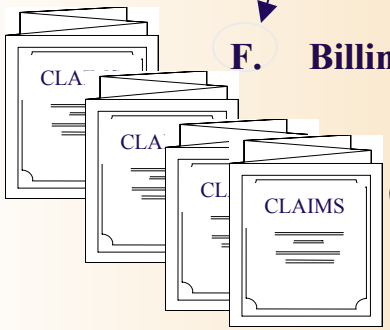
E. Coding

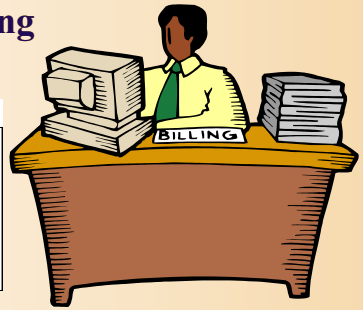
G. Itemized Posting



C. Patient Care

F. Billing





D. Disposition

Health Information Mgmt.
a. Documentation
b. Diagnosis/Procedure Coding

Impact of Itemized Billing

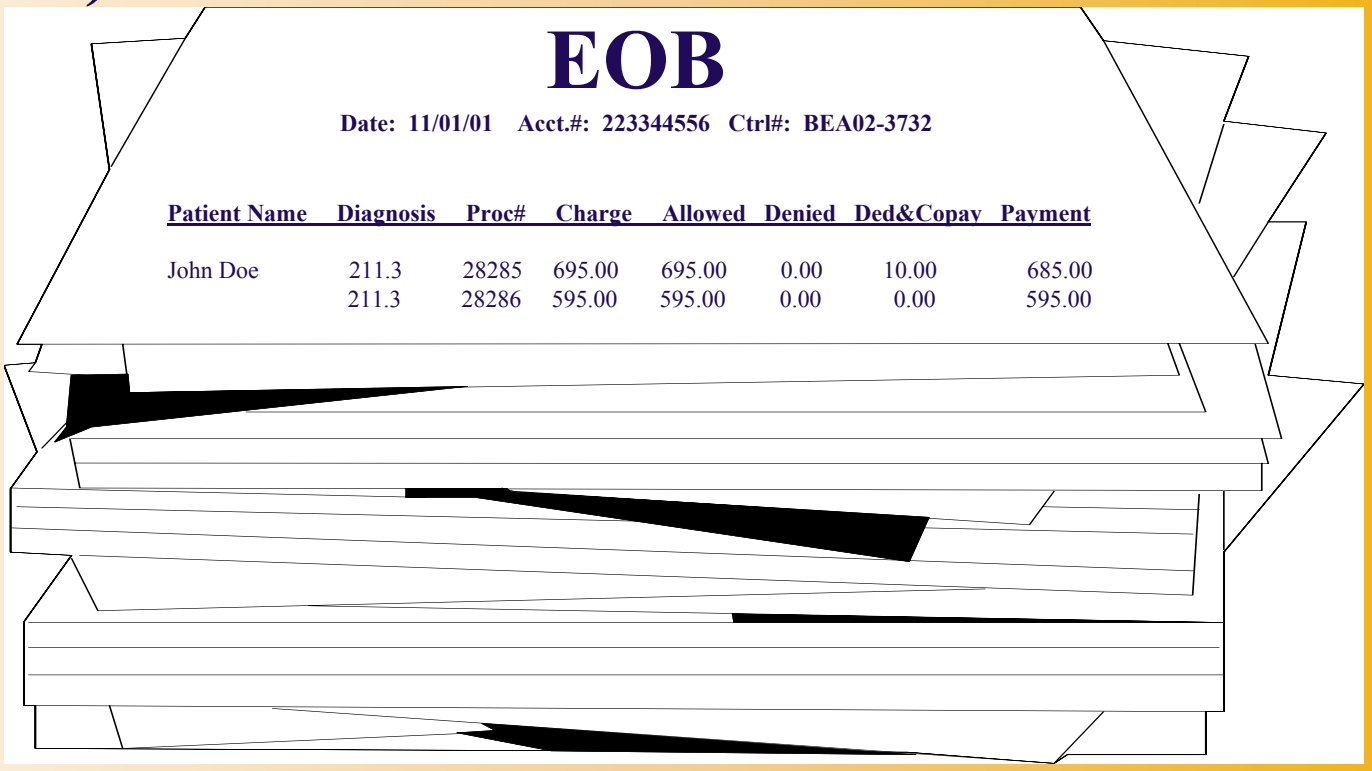
- **Changes in MTF-wide business operations:**
  - Evaluation of current business practices: (revenue cycle)
    - Increased workload (e.g. multiple claim forms/encounter)
    - Additional resources (e.g. equipment, FTEs)
    - Optimization of revenue
    - More automated process
- **Stakeholders involved:**
  - **DoD**
    - Providers
    - Coders
    - Billers
    - Clerks
    - Registration
    - Patients
  - **Payers**
  - **Systems**

Impact on DoD Provider/Staff

- **Ability to code based on specific care provided to the patient with the use of modifiers:**
  - Bilateral procedures
  - Multiple biopsies
  - Multiple surgery providers
- **Use of professional and technical component for reading and performing a test when applicable**
- **Additional Claims Processing:**
  - Enhanced Automation
  - Auditing (internal or external)
  - Increased Follow-up

Impact on DoD Patients

- **Easier interpretation of Explanation of Benefits (EOB)**



EOB

Date: 11/01/01 Acct.#: 223344556 Ctrl#: BEA02-3732

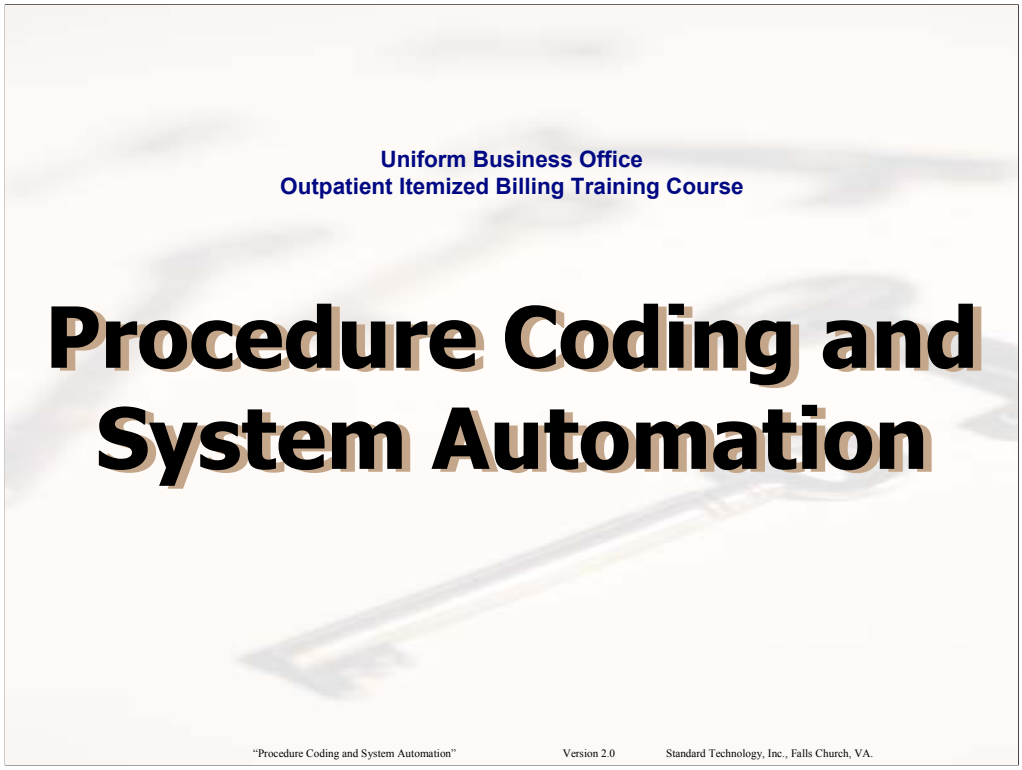
Patient Name	Diagnosis	Proc#	Charge	Allowed	Denied	Ded&Copay	Payment
John Doe	211.3	28285	695.00	695.00	0.00	10.00	685.00
	211.3	28286	595.00	595.00	0.00	0.00	595.00

Impact on Payers

- Aligns DoD claims with civilian sector by using industry standards
- Easier to understand and process
- Reimburse line item charges
- Allows payers to conduct accurate research and analysis of disease and social trends based on utilization of services

Impact on Systems

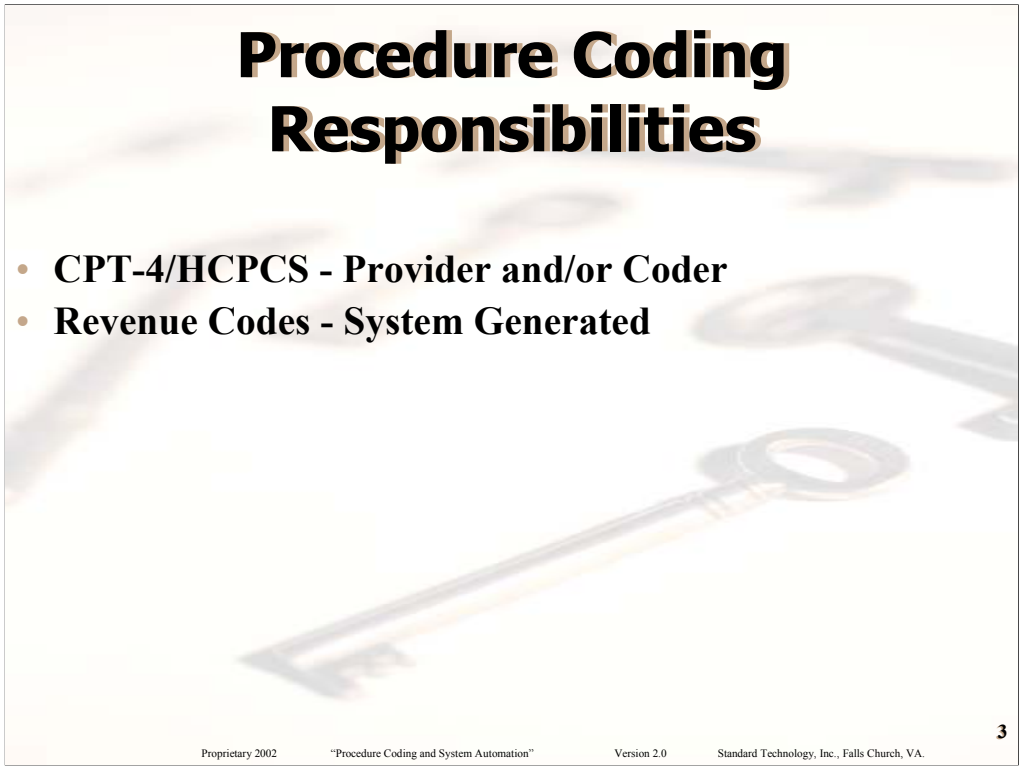
- Synchronization of TPOCS/CHCS Standard Insurance Table (SIT) and Other Health Insurance (OHI)
- Automation of pharmacy, laboratory and radiology data transfer
- New Rate Tables
- Accommodate Medical Services Account (MSA) billing within CHCS
- Secure and efficient electronic billing capabilities



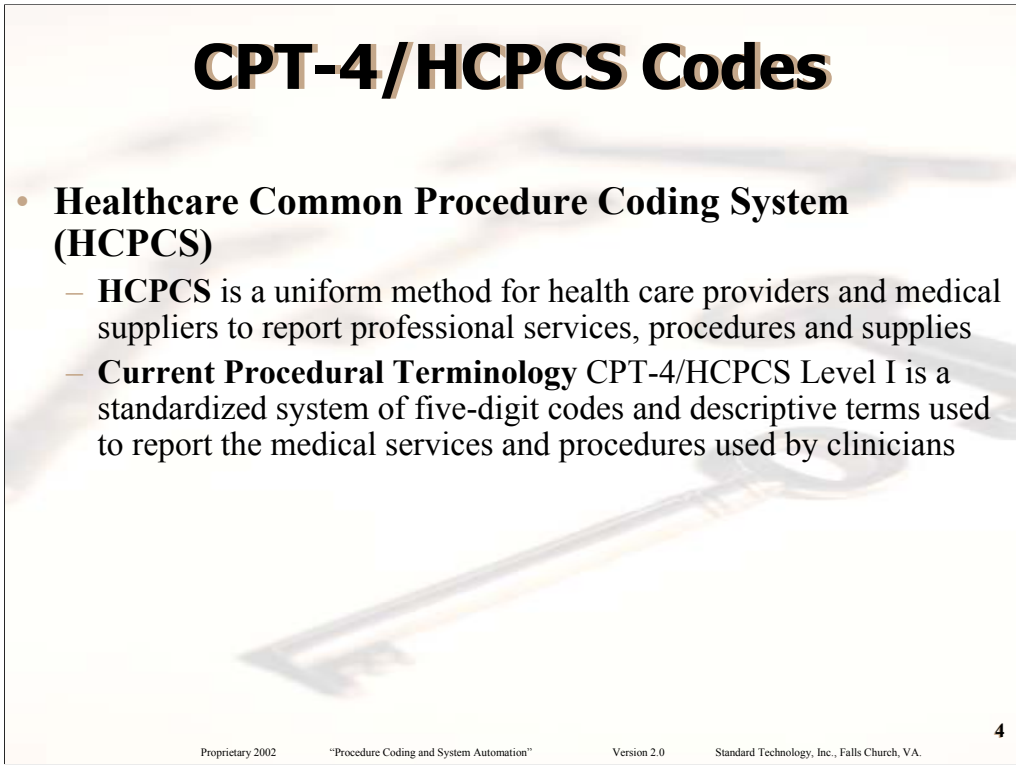
- This is a functional overview of Revenue and CPT-4 codes and how these codes feed into the Outpatient Itemized Billing process.

Objectives

- **Explain procedure coding responsibilities**
- **Explain how an encounter becomes a bill**
- **Identify system default claim forms**
- **Discuss revenue code mapping**
- **Explain rate tables and calculating charges**



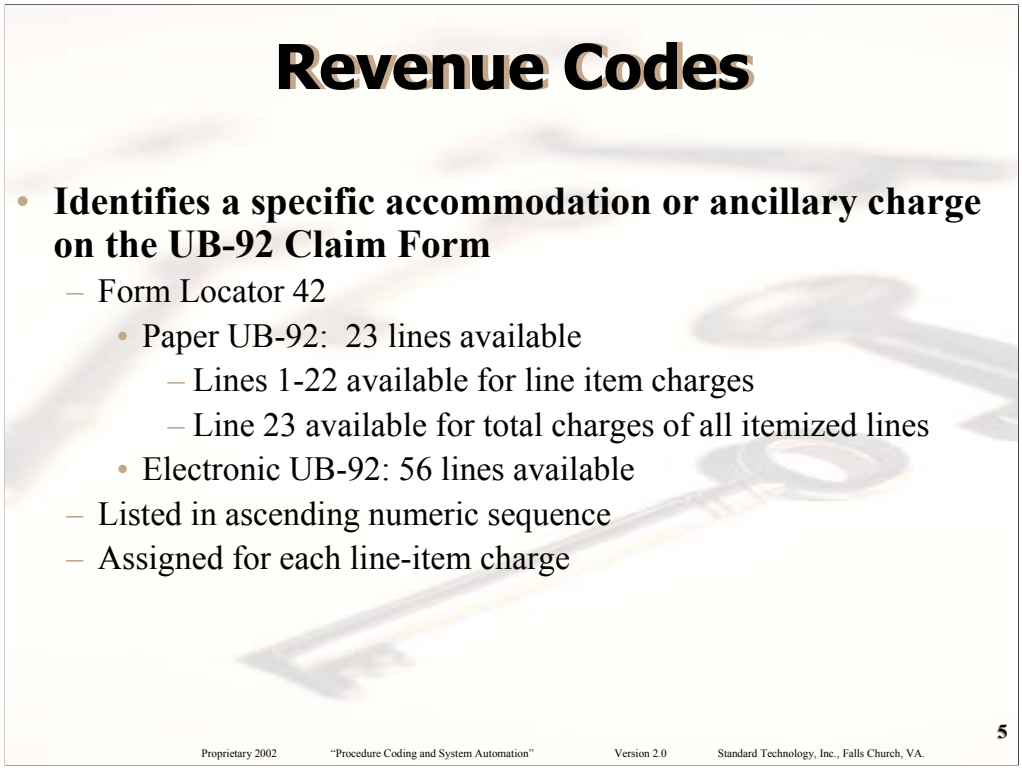
• CPT-4 means Current Procedure Terminology 4th Edition.



- As a biller, you are **NOT** responsible for coding medical procedures and services. The provider/coder is the responsible party.

- The **HCPCS** system consists of three levels of codes:
  - **Level I** - Level I is the American Medical Association's CPT-4 codes.
  - **Level II** - HCPCS National Codes - Alpha-numeric five digit codes representing medical services and supplies that are not included in Level I. (Used mainly for reimbursement of Medicare and Medicaid claims)
  - **Level III** - Local Codes - Alpha-numeric five digit codes, which describe new procedures that are not yet available in Level I and II.
  - If you want to know more about the actual HCPCS codes, look at references such as the HCPCS book, which comes out yearly.

- **CPT-4** codes are developed, updated and published yearly by the American Medical Association:
  - CPT-4 codes communicate to providers, patients and payers the procedures performed during a medical encounter.
  - Accurate CPT-4 coding is crucial for proper reimbursement from payers and compliance with government regulations.
  - If you want to know more about the actual CPT-4 codes, look at references such as the CPT book, which comes out yearly.

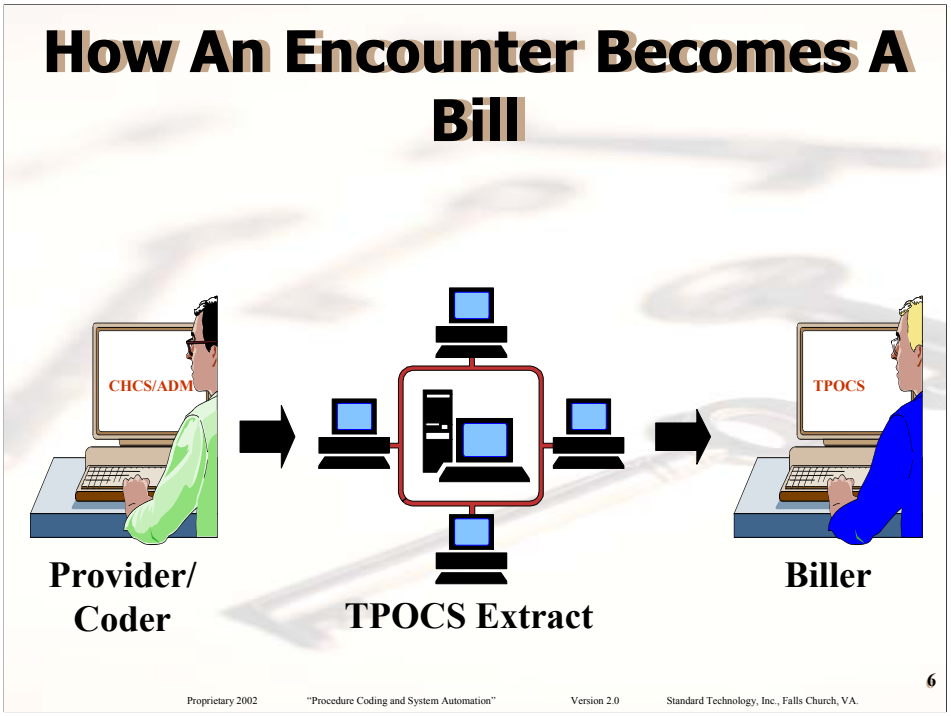


- Familiarity of revenue codes is the responsibility of the biller. This is a high level overview and we will not be going into detail on all revenue codes. For more information on actual revenue codes, refer to the UB-92 Editor.

- Revenue codes are used on the UB-92 Claim Form only:
  - They will be populated on Form Locator 42.

- Listed in numeric sequence except for revenue code 001 (total charges), which goes at the end of all the line items for the sum of all the charges.

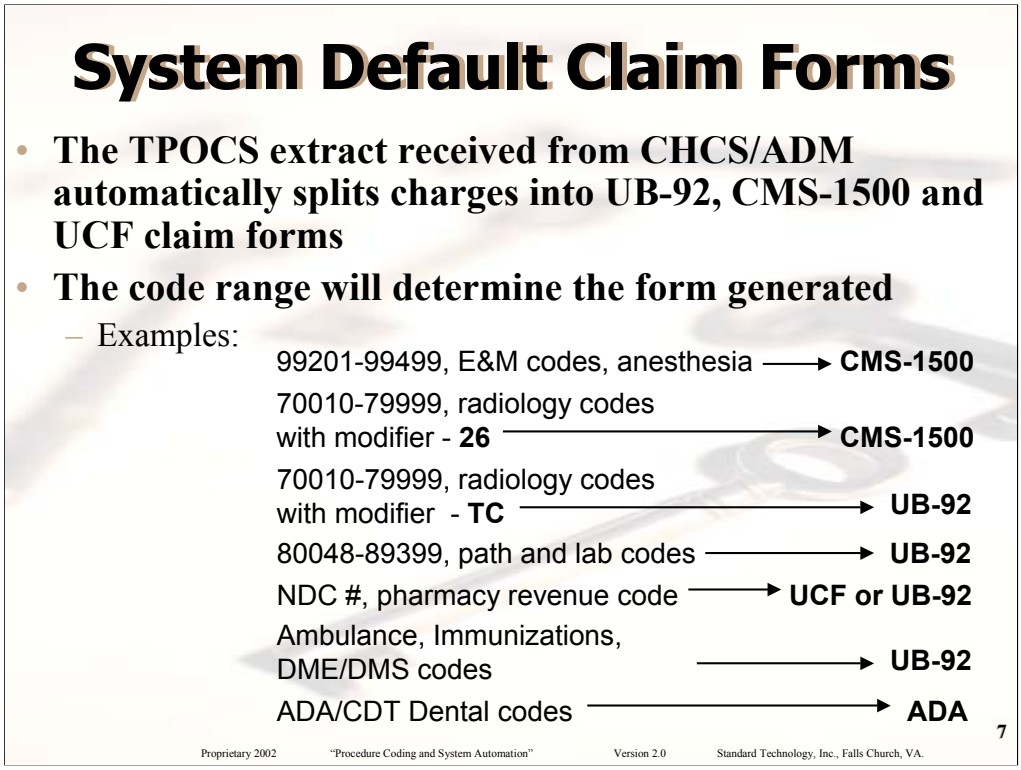
- Examples of **Revenue Codes**:
  - 320 = Radiology – Diagnostic
  - 333 = Radiation Therapy
  - 450 = Emergency Room – General
  - 545 = Air Ambulance



- CPT-4/HCPCS Coding completed by Provider/Coder in CHCS/ADM:
  - Even though the biller is not responsible for the actual procedure/service coding, if the biller questions the validity, the bill may be put in a suspense file until procedure/service coding is validated.
  - If coding changes need to be made, they will have to be done by the provider/coder in the source system (CHCS/ADM).

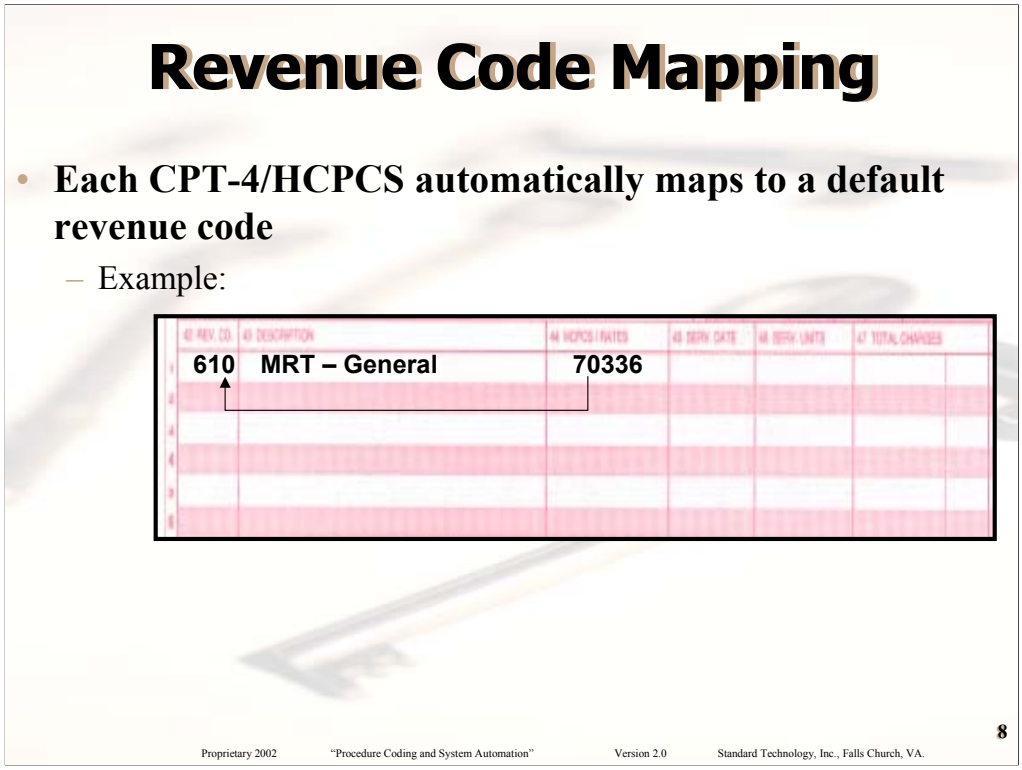
- TPOCS Extract - CHCS/ADM will provide downloads of outpatient appointment encounter data and patient demographics and send it to TPOCS:
- Hold periods have been put in place to cut down the number of claims.
  - Prior to transmission, there is a 72 hour hold period to allow for entry of OHI information in CHCS.
  - TPOCS will hold the information for 7 days to allow time for the coding of any additional ancillary services (lab and rad) and 14 days for pharmacy services that were not performed in the same clinic as the original encounter.
  - If during the hold period, the ancillary services come across in the TPOCS extract, then the system will match up the ancillary service with the original encounter and be billed on one UB-92 claim form.
  - If the ancillary services were not coded before the original encounter is billed, then they will be billed on a different UB-92 claim form
    - NOTE: when the hold period is up, the bill will NOT automatically be sent to the payer. The biller must still verify the information on the claims before queuing the bill.

    Note: Although certain fields are not requirements in CHCS, they may be required in TPOCS. If a required field is not populated, the encounter will not be sent to TPOCS (e.g. Patient Address)
  - If there is incomplete/missing information, the entire encounter record will not transfer to the TPOCS extract.
- When codes (ICD-9-CM, CPT-4/HCPCS) are added or removed from the previously filed encounter, it is sent in a new extract to TPOCS as an updated record:
  - This updated record is a replacement for the previous encounter record and contains all the information, not just the updated information.
  - The bill can then be validated and finalized by the biller.



- TPOCS is able to determine this by the individual CPT-4 codes:
  - TPOCS contains a mapping which determines on which form to place the code based on the range the CPT-4/HCPCS code is in. The examples are not all inclusive:
    - When TPOCS reads a code in the E&M series, it automatically will put it on the CMS-1500 Claim Form.
    - When TPOCS reads a code in the 70000 radiology series with a 26 modifier, it automatically will put it on the CMS-1500 Claim Form.
    - When TPOCS reads a code in the 70000 radiology series with a TC modifier, it automatically will put it on the UB-92 Claim Form.
    - When TPOCS reads a code in the 80000 path and lab series, it automatically will put it on the UB-92 Claim Form.
    - When TPOCS reads an NDC number, it will automatically put it on the UCF.
      - **Note: Pharmacy charges can also be produced on the UB-92 if requested by the payer.**
    - When TPOCS reads Ambulance, Immunizations and DME/DMS services, it automatically put it on the UB-92 Claim Form.
  - This process is a default process:
    - If a particular payer wants all charges on the UB-92, then the biller has the ability to switch the claim form.

- Dental information is **manually entered on the ADA Claim Form by the biller.**



- As previously stated when discussing revenue codes, they only apply to the UB-92 Claim Form.

- The biller does not have to manually enter the revenue code to finalize the bill.

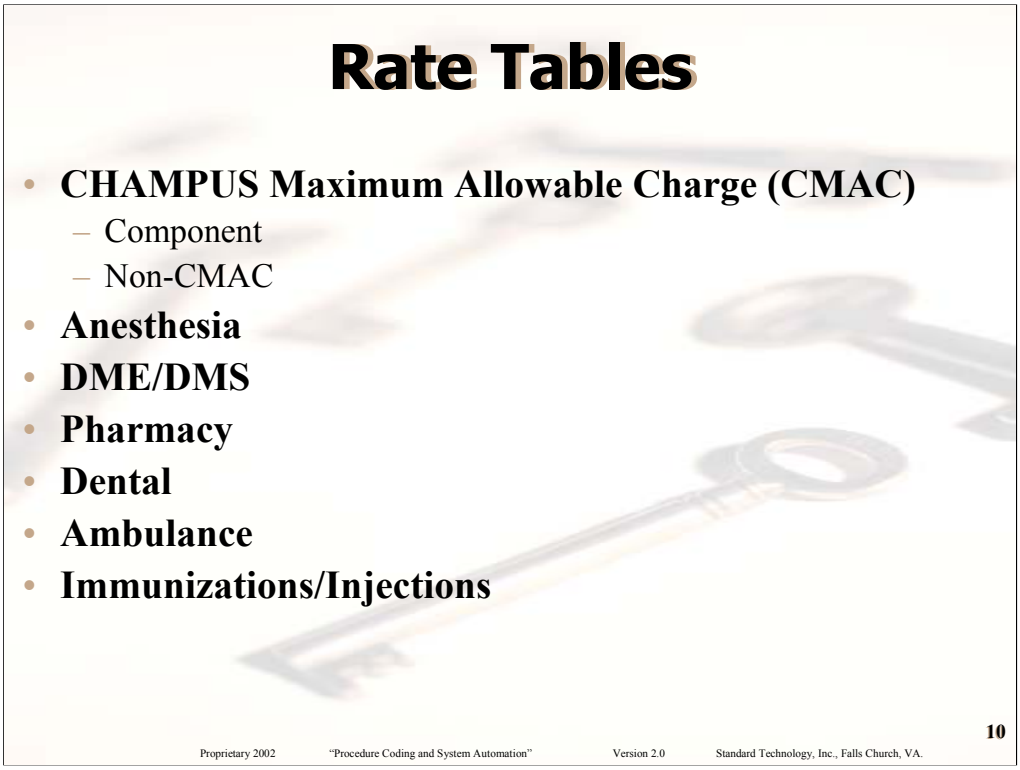
- TPOCS contains a mapping that will automatically default to a revenue code based on the CPT-4/HCPCS code:
  - For example, with the code 70336, MRI jaw joint, revenue code 610, MRT-General will appear.
  - All CPT-4/HCPCS codes will be mapped to one of five primary revenue codes.
  - The biller will have the ability to change this revenue code to one of the other four or enter a new code in the blank column.

Note to Trainer: Have class refer to the Revenue Code to CPT Code Mapping example attached at the end of this presentation.

How To Calculate Charges

- **Revenue codes do not generate a charge**
- **CPT-4/HCPCS codes generate charges automatically from rate tables**

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	
420	Treatments Physical Therapy	97032	10012001	1	20	82
420	Treatments Physical Therapy	97110	10012001	1	27	60
001	Total			2	$48	42



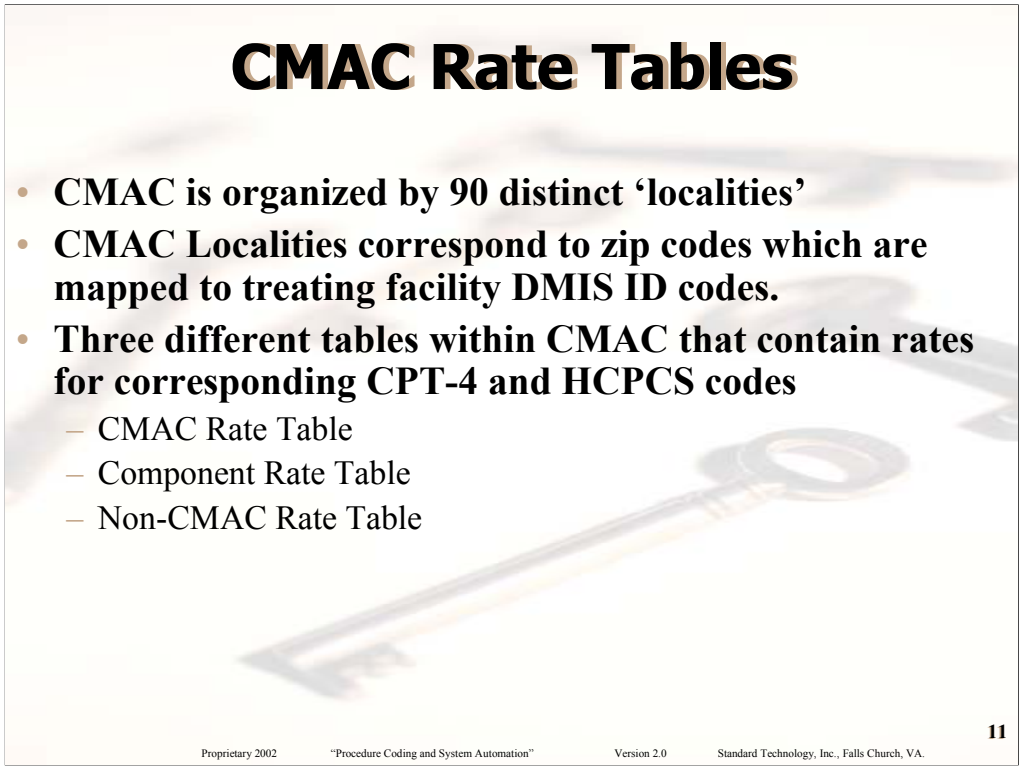
• The systems (both CHCS and TPOCS) will contain the following rate tables:

– **CMAC**
– **Non-CMAC**
– **Component**
– **Anesthesia**
– **DME/DMS**
– **Pharmacy**
– **Dental**
– **Ambulance**
– **Immunizations/Injections**

• All rate tables will be **updated yearly.**

• If you do multi-site billing then your system will be loaded with all the rates tables that you will need to bill for each MTF.

• The system will automatically choose the correct rate based on the treating MTF DMIS ID.

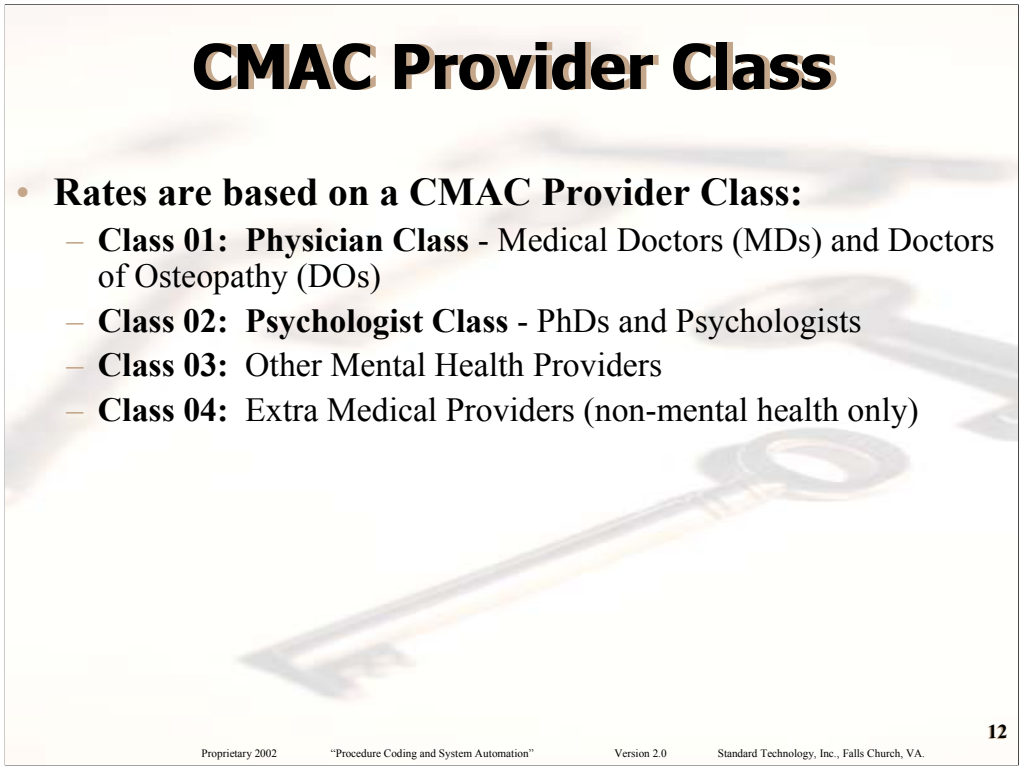


- In order to obtain CMAC pricing for a CPT-4 or HCPCS Level I, II or III code, a locality code is essential:
  - There are currently 90 different locality codes
    - Localities account for differences in geographic regions based on demographics, cost of living and population (e.g., New York City vs. a city in Iowa).
  - Each facility DMIS ID will map to a specific locality code.

- For each locality code, there are three rate tables:
  - **CMAC Rate Table:** This rate table has the majority of codes.
  - **Component Rate Table:** This rate table contains the rates for codes which are broken down into professional (modifier -26) and technical (modifier -TC) components.
    - When these modifiers (-26 and –TC) are used, the system will select the rate from this table.

  - **Non-CMAC Rate Table:** This table contains the rates for the procedures which are normally priced on a statewide basis (prevailing fees).

- The CMAC rate tables contain the rates for rad, lab, clinic procedures/services and E&M codes.



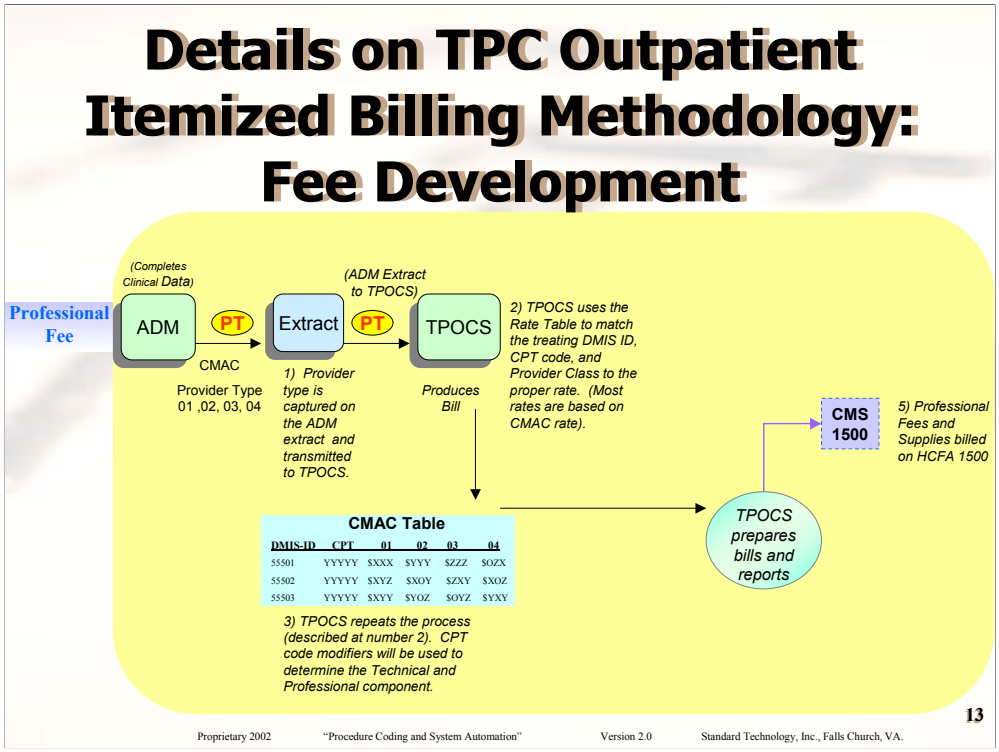
• Each CHCS provider type has been mapped to a CMAC provider class based on medical specialty in CHCS for billing purposes.

• These CHCS provider types will also be aligned with the HIPAA Taxonomy.

• The HIPAA Taxonomy assigns every class of provider to a specific code so that they can be readily identified by the payer. This is essential, especially for electronic billing.

• DoD is scheduled to be HIPAA compliant by FY03.

Note to Trainer: Have class refer to the HIPAA Taxonomy to CMAC Provider Class Mapping attached at the end of this presentation.



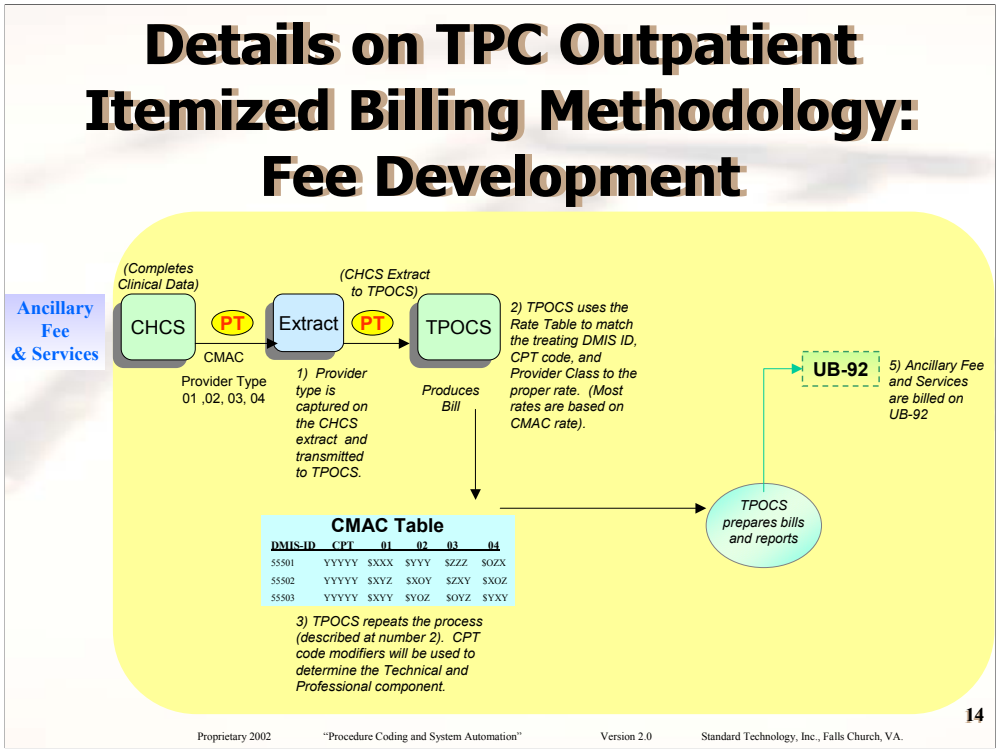
•Details of Professional Fee development:

–Clinical data entered in ADM

–Provider Class attached in ADM Extract and sent to TPOCS

–TPOCS matches rate to CMAC Rate Tables (if no rate can be determined then do not bill for service)

–TPOCS prepares bill and prints it on appropriate claim form



•Details of Ancillary Fee development:

–Clinical data entered in CHCS

–CHCS Extract sent to TPOCS

–TPOCS matches rate to CMAC Rate Tables (if no rate can be determined then do not bill for service)

–TPOCS prepares bill and prints it on appropriate claim form

Anesthesia Rate Table

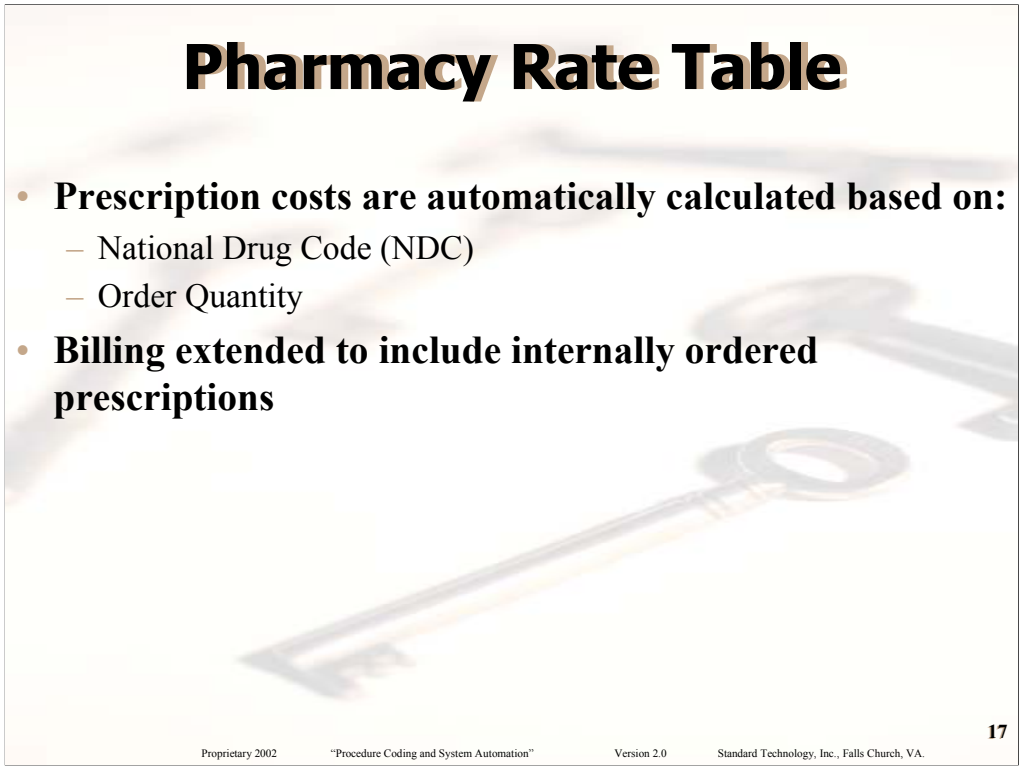
- **Automatically calculates charges for Anesthesia services based on:**
  - CPT-4 Codes 00100-01999
- **Flat Rate for this range of codes**

DME/DMS Rate Table

- **Automatically calculates charges for Durable Medical Equipment/Durable Medical Supplies based on:**
  - HCPCS Level II "A, E, K, L, and V" codes
    - A4214 - A7509
    - E0100 - E2101
    - K0001 - K0551
    - L0100 - L8670
    - V2020 - V2780

16

- A codes: Medical and Surgery Supplies
- E codes: Durable Medical Equipment
- K codes: Temporary Codes Assigned to Durable Medical Equipment
- L codes: Prosthetic/Orthotic Procedures
- V codes: Vision Services



• Rates are based on the NDC number.

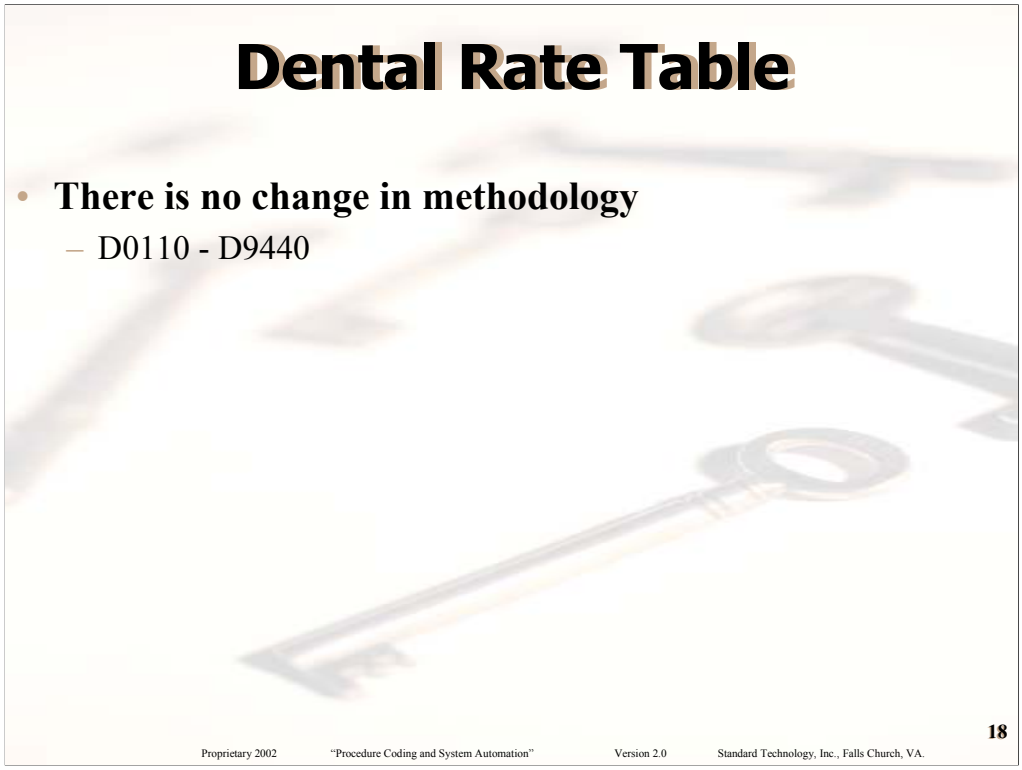
• Pharmacy rates are updated quarterly.

• **NDC:** Each drug product listed under Section 510 of the Federal Food, Drug and Cosmetic Act is assigned a unique 10-digit, 3-segment number.

– Identifies the labeler/vendor, product and trade package size

• The first segment, **labeler** code, is FDA assigned. A labeler is any firm that manufactures, repacks or distributes a drug product.
• The second segment, **product** code, identifies a specific strength, dosage form and formulation for a particular firm.
• The third segment, package code, identifies **package sizes.**
– Both the product and package codes are assigned by the firm.

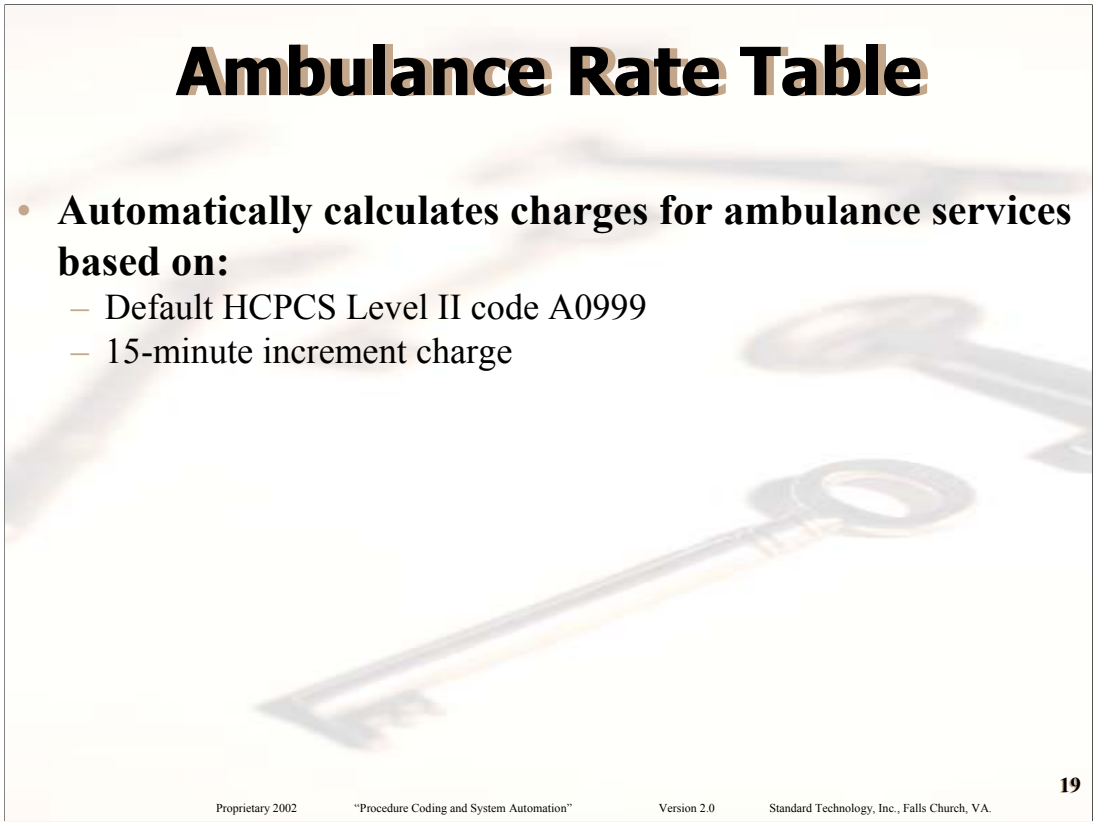
• If the pharmacy table does not contain a rate for a particular drug, it cannot be billed.
• Order Quantity is based on MTF Pharmacy file.
• A Dispensing Fee will be automatically added to the pharmacy bill.



• Billed on the ADA Claim Form.

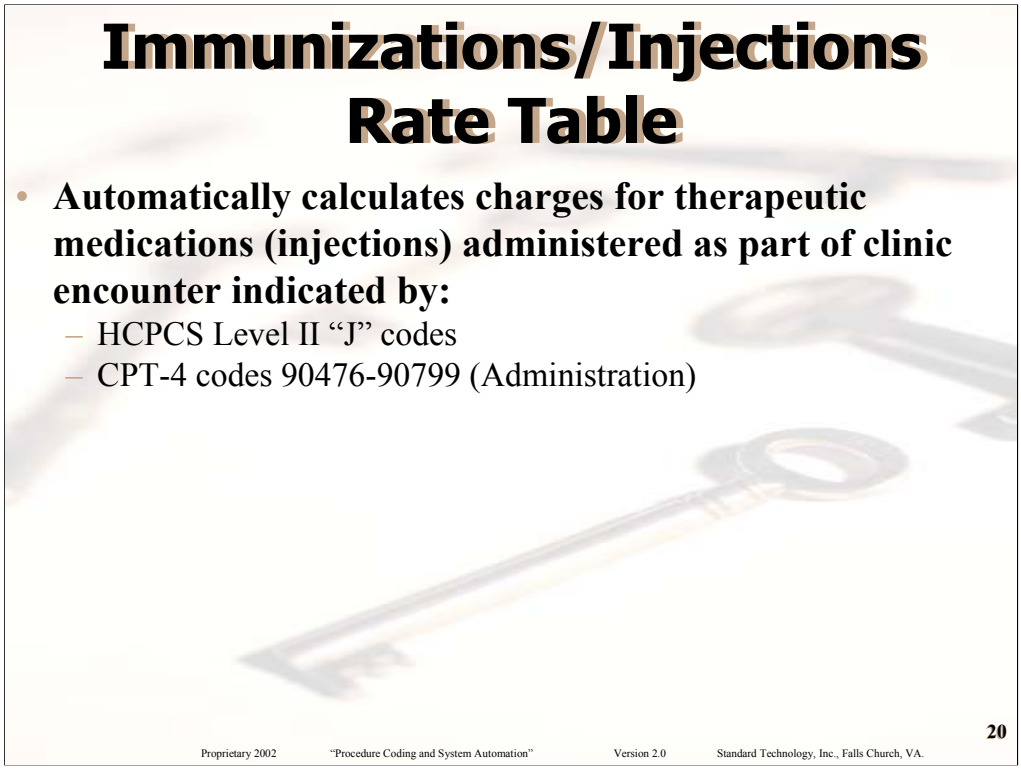
• Updated yearly

• **D codes:** Dental procedures which can be:
  – Diagnostic
  – Restorative
  – Periodontics
  – Maxillofacial prosthetics
  – Prosthodonics (fixed)
  – Oral and maxillofacial surgery
  – Adjunctive general services



• Ambulance encounters will be extracted from CHCS.

• The biller will have to enter the time increment in order for TPOCS to calculate the appropriate charge.



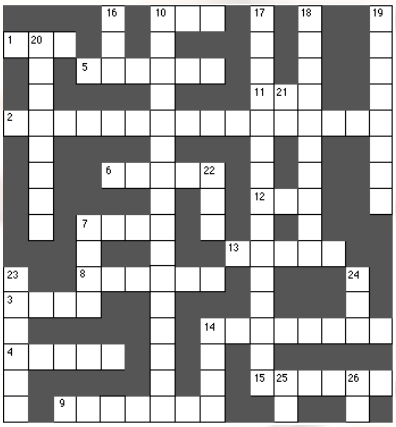
- **J codes:** Drugs administered other than by mouth. (J0000-J8999)
- **CPT-4 codes 90476-90799**
  - Vaccines
  - Toxoids
  - Therapeutic or Diagnostic

Missing Rates

- **All HCPCS Level I, II and III codes must have an associated rate to be billed to the insurance carrier, otherwise, the code cannot be billed!**

Key Points

- **There will be a daily data feed into TPOCS**
- **There will be no capability of manual entry of SIT/OHI information into TPOCS**
- **TPOCS contains a CPT to revenue code mapping that will ease the work of the biller in choosing revenue codes for each line item**
  - TPOCS will default a revenue code for each CPT that comes across; the biller will be able to choose up to 4 other listed revenue codes from a drop down box in addition to typing in a revenue code of the biller's choice



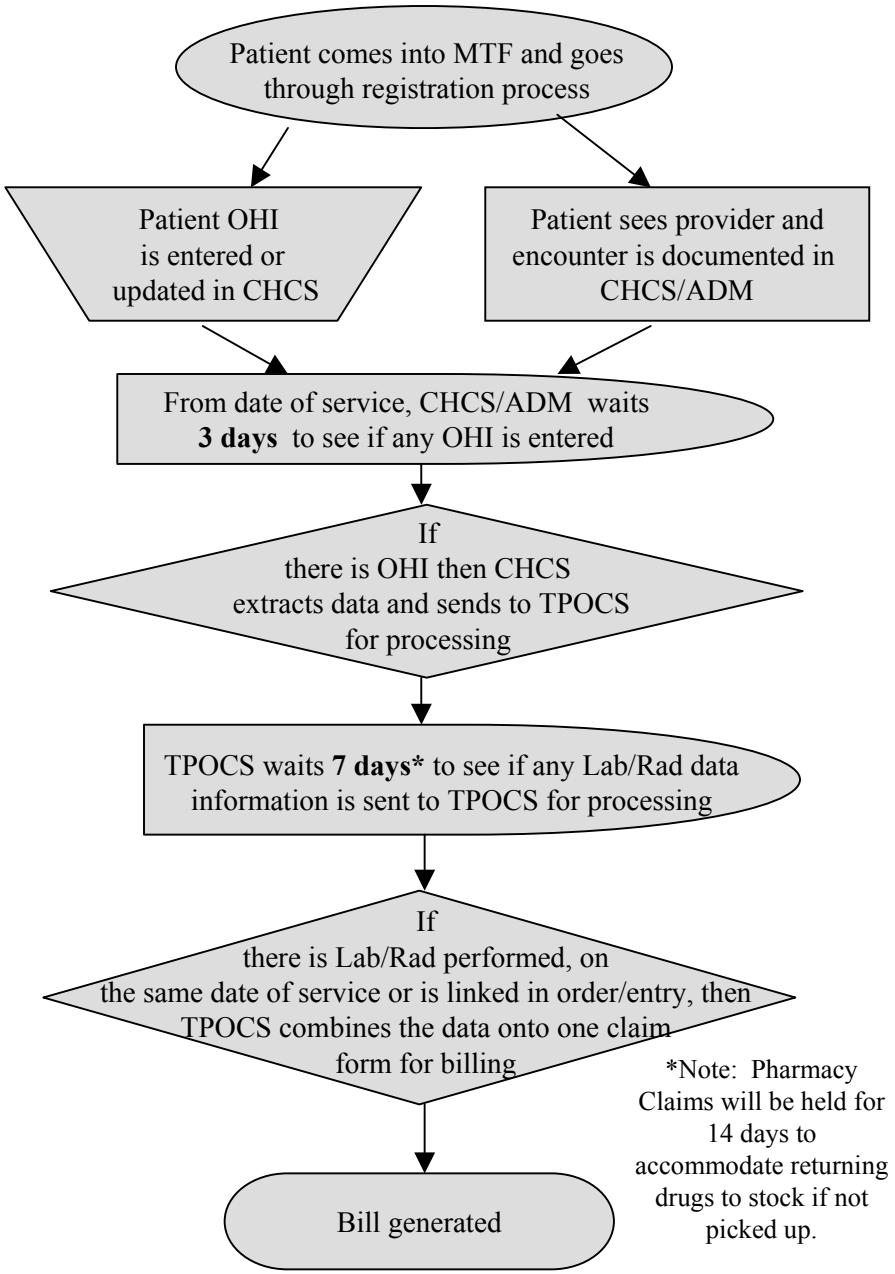
Coding & System Automation Review
Crossword Puzzle

NOTE TO TRAINER: Have participants do Crossword Puzzle and check.

Have participants refer to the following handouts and discuss:

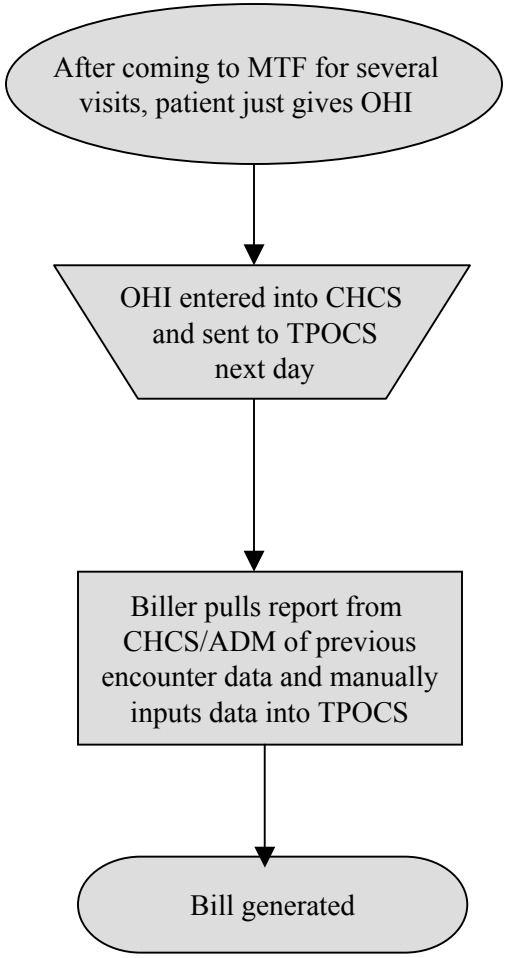
- **"Automated Claims vs. Manual Claims"**
- **"Outpatient Itemized Billing System Hold Periods"**
- **"Rate Tables and Claim Form Selection**"

Automated Claims



*Note: Pharmacy Claims will be held for 14 days to accommodate returning drugs to stock if not picked up.

Manual Claims



HIPAA Taxonomy to CMAC Provider Class Mapping

HIPAA Code	HIPAA Provider Taxomony Codes and Descriptions	Provider Classification (KG-ADS)	CHCS Code	CHCS Provider Specialty Type Codes and Descriptions	CMAC Provider Class
101YA0400N	Counselor Addiction (Substance Use Disorder)	DCP	074	Alcohol Abuse Counselor	04
101YA0400N	Counselor Addiction (Substance Use Disorder)	DCP	075	Drug Abuse Counselor	04
103S00000N	Psychoanalyst	DCP	072	Psychoanalyst	02
103TC0700N	Psychologist Clinical	DCP	702	Clinical Psychologist	02
1041C0700N	Social Worker Clinical	DCP	703	Psychology Social Worker	03
111N00000N	Chiropractor	DCP	713	Contract Chiropractor	01
122300000N	Dentist	DENT	812	Dental Officer General	01
122300000N	Dentist	DENT	813	Dental Officer Resident	01
122300000N	Dentist	DENT	517	Dental Consultant	01
1223E0200Y	Dentist Endodontics	DENT	810	Endodontist	01
1223E0200Y	Dentist Endodontics	DENT	811	Endodontic Resident	01
1223P0106Y	Dentist Pathology, Oral & Maxillofacial	DENT	808	Oral Pathologist	01
1223P0106Y	Dentist Pathology, Oral & Maxillofacial	DENT	809	Oral Pathology Resident	01
1223P0221Y	Dentist Pediatrics Dentistry (Pedodontics)	DENT	815	Pedodontist	01
1223P0221Y	Dentist Pediatrics Dentistry (Pedodontics)	DENT	816	Pedodontic Resident	01
1223P0300Y	Dentist Periodontics	DENT	802	Periodontist	01
1223P0300Y	Dentist Periodontics	DENT	803	Periodontic Resident	01
1223P0700Y	Dentist Prosthodontics	DENT	804	Prosthodontist	01
1223P0700Y	Dentist Prosthodontics	DENT	805	Prosthodontic Resident	01
1223S0112Y	Dentist Surgery, Oral & Maxillofacial	DENT	800	Oral Surgeon	01
1223S0112Y	Dentist Surgery, Oral & Maxillofacial	DENT	801	Oral Surgery Resident	01
1223X0400Y	Dentist Orthodontics	DENT	806	Orthodontist	01
1223X0400Y	Dentist Orthodontics	DENT	807	Orthodontic Resident	01
126800000N	Dental Assistant	TECH	902	Dental Assistant	04
133V00000N	Dietician, Registered	DCP	704	Dietician-Nutritionist	04
146L00000N	Emergency Medical Technician, Paramedic	TECH	900	Independent Duty Corpsman/Independent Medical Technician	
152W00000N	Optometrist	DCP	708	Optometrist	04
163W00000N	Registered Nurse	RN	600	Nurse, General Duty	04
163WC1500N	Registered Nurse Community Health	RN	607	Community Health Nurse	04
163WF0300N	Registered Nurse Flight	RN	606	Aerospace Nurse	04
163WP0808N	Registered Nurse Psychiatric/Mental Health	RN	601	Mental Health Nurse	03
1835P1200N	Pharmacist Pharmacotherapy	PHARM	202	Medical Chemist	04
203B00000N	Physician/Osteopath	PHYS	002	Contract Physician	01

HIPAA Taxonomy to CMAC Provider Class Mapping

HIPAA Code	HIPAA Provider Taxomony Codes and Descriptions	Provider Classification (KG-ADS)	CHCS Code	CHCS Provider Specialty Type Codes and Descriptions	CMAC Provider Class
203B00000N	Physician/Osteopath	PHYS	500	Senior Staff Physician	01
203B00000N	Physician/Osteopath	PHYS	518	Other Consultant	01
203BA0000Y	Physician/Osteopath Adolescent Medicine	PHYS	042	Adolescent Medicine Physician	01
203BA0100Y	Physician/Osteopath Aerospace Medicine	PHYS	300	Aerospace Medicine Physician	01
203BA0100Y	Physician/Osteopath Aerospace Medicine	PHYS	301	Aerospace Medicine Resident	01
203BA0100Y	Physician/Osteopath Aerospace Medicine	PHYS	302	Aerospace Medicine Flight Surgeon/Family Practice Physician	01
203BA0100Y	Physician/Osteopath Aerospace Medicine	PHYS	514	Aerospace Medicine Consultant	01
203BA0200N	Physician/Osteopath Allergy	PHYS	012	Allergist	01
203BA0200N	Physician/Osteopath Allergy	PHYS	041	Allergist, Pediatric	01
203BA0300Y	Physician/Osteopath Anesthesiology	PHYS	092	092 Anesthesiologist	01
203BA0300Y	Physician/Osteopath Anesthesiology	PHYS	093	093 Anesthesiology Resident	01
203BA0300Y	Physician/Osteopath Anesthesiology	PHYS	501	Anesthesiology Consultant	01
203BC0100Y	Physician/Osteopath Cardiology	PHYS	014	Cardiologist	01
203BD0100Y	Physician/Osteopath Dermatology	PHYS	044	Dermatologist, Pediatric	01
203BD0100Y	Physician/Osteopath Dermatology	PHYS	080	Dermatologist	01
203BD0100Y	Physician/Osteopath Dermatology	PHYS	081	Dermatology Resident	01
203BD0100Y	Physician/Osteopath Dermatology	PHYS	506	Dermatology Consultant	01
203BE0004Y	Physician/Osteopath Emergency Medicine	PHYS	004	Emergency Physician	01
203BE0004Y	Physician/Osteopath Emergency Medicine	PHYS	005	Emergency Physician Resident	01
203BE0100Y	Physician/Osteopath Endocrinology	PHYS	016	Endocrinologist	01
203BE0101Y	Physician/Osteopath Endocrinology, Diabetes & Metabolism	PHYS	023	Metabolic Diseases Physician	01
203BE0101Y	Physician/Osteopath Endocrinology, Diabetes & Metabolism	PHYS	047	Metabolic Diseases Physician, Pediatric	01
203BF0100Y	Physician/Osteopath Family Practice	PHYS	001	Family Practice Physician	01
203BF0100Y	Physician/Osteopath Family Practice	PHYS	003	Family Practice Physician Resident	01
203BF0201Y	Physician/Osteopath Forensic Pathology	PHYS	204	Pathologist, Forensic	01

HIPAA Taxonomy to CMAC Provider Class Mapping

HIPAA Code	HIPAA Provider Taxomony Codes and Descriptions	Provider Classification (KG-ADS)	CHCS Code	CHCS Provider Specialty Type Codes and Descriptions	CMAC Provider Class
203BG0000Y	Physician/Osteopath General Practice	PHYS	000	General Medical Officer	01
203BG0100Y	Physician/Osteopath Gastroenterology	PHYS	018	Gastroenterologist	01
203BG0200Y	Physician/Osteopath Genetics, Medical	PHYS	025	Medical Geneticist	01
203BG0300N	Physician/Osteopath Geriatric Medicine	PHYS	017	Geriatrician	01
203BH0000Y	Physician/Osteopath Hemotology	PHYS	019	Hematologist	01
203BI0200Y	Physician/Osteopath Infectious Diseases	PHYS	022	Infectious Diseases Physician	01
203BI0300Y	Physician/Osteopath Internal Medicine	PHYS	011	Internist	01
203BI0300Y	Physician/Osteopath Internal Medicine	PHYS	028	Internal Medicine Resident	01
203BI0300Y	Physician/Osteopath Internal Medicine	PHYS	502	Internal Medicine Consultant	01
203BL0000Y	Physician/Osteopath Laboratory Medicine	PHYS	015	Cardiopulmonary Laboratory Physician	01
203BM0101Y	Physician/Osteopath Maternal & Fetal Medicine	PHYS	046	Perinatologist	01
203BN0300Y	Physician/Osteopath Nephrology	PHYS	024	Nephrologist	01
203BN0400Y	Physician/Osteopath Neurology	PHYS	060	Neurologist	01
203BN0400Y	Physician/Osteopath Neurology	PHYS	061	Neurologist Resident	01
203BN0400Y	Physician/Osteopath Neurology	PHYS	504	Neurology Consultant	01
203BN0500Y	Physician/Osteopath Neuropathology	PHYS	205	Neuropathologist	01
203BN0700Y	Physician/Osteopath Neuroradiology	PHYS	402	Neuro-Radiologist	01
203BN0900Y	Physician/Osteopath Nuclear Medicine	PHYS	027	Nuclear Medicine Physician	01
203BN0900Y	Physician/Osteopath Nuclear Medicine	PHYS	206	Nuclear Medicine Pathologist	01
203BN0904Y	Physician/Osteopath Nuclear Radiology	PHYS	403	Nuclear Medicine Radiologist	01
203BP0100Y	Physician/Osteopath Pathology	PHYS	153	Pathologist OB/GYN	01
203BP0100Y	Physician/Osteopath Pathology	PHYS	200	Pathologist	01
203BP0100Y	Physician/Osteopath Pathology	PHYS	207	Pathology Resident	01
203BP0200Y	Physician/Osteopath Pediatrics	PHYS	040	Pediatrician	01
203BP0200Y	Physician/Osteopath Pediatrics	PHYS	052	Pediatric Resident	01
203BP0200Y	Physician/Osteopath,	PHYS	503	Pediatric Medicine	01

HIPAA Taxonomy to CMAC Provider Class Mapping

HIPAA Code	HIPAA Provider Taxomony Codes and Descriptions	Provider Classification (KG-ADS)	CHCS Code	CHCS Provider Specialty Type Codes and Descriptions	CMAC Provider Class
	Pediatrics			Consultant	
203BP0202Y	Physician/Osteopath Pediatric Cardiology	PHYS	043	Cardiologist, Pediatric	01
203BP0205Y	Physician/Osteopath Pediatric Endocrinology	PHYS	045	Endocrinologist, Pediatric	01
203BP0206Y	Physician/Osteopath Pediatric Gastroenterology	PHYS	053	Gastroenterologist, Pediatric	01
203BP0207Y	Physician/Osteopath Pediatric Hematology Oncology	PHYS	048	Hematologist, Pediatric	01
203BP0208Y	Physician/Osteopath Pediatric Infectious Diseases	PHYS	051	Infectious Diseases Physician, Pediatric	01
203BP0210Y	Physician/Osteopath Pediatric Nephrology	PHYS	054	Nephrologist, Pediatric	01
203BP0211Y	Physician/Osteopath Pediatric Neurology	PHYS	049	Neurologist, Pediatric	01
203BP0214Y	Physician/Osteopath Pediatric Pulmonology	PHYS	050	Pulmonary Disease Physician, Pediatric	01
203BP0400Y	Physician/Osteopath Physical Medicine & Rehabilitation	PHYS	090	Physical Medicine Physician	01
203BP0400Y	Physician/Osteopath Physical Medicine & Rehabilitation	PHYS	507	Physical Medicine Consultant	01
203BP0500Y	Physician/Osteopath Preventive Medicine, General	PHYS	320	Preventive Medicine Physician	01
203BP0500Y	Physician/Osteopath Preventive Medicine, General	PHYS	515	Preventive Medicine Consultant	01
203BP0800Y	Physician/Osteopath Psychiatry	PHYS	070	Psychiatrist	01
203BP0800Y	Physician/Osteopath Psychiatry	PHYS	073	Psychiatric Resident	01
203BP0800Y	Physician/Osteopath Psychiatry	PHYS	505	Psychiatry Consultant	01
203BP0803Y	Physician/Osteopath Psychiatry, Child	PHYS	071	Child Psychiatrist	01
203BP0901N	Physician/Osteopath Public Health & General Preventive Medicine	PHYS	026	Tropical Medicine Physician	01
203BP1003Y	Physician/Osteopath Pulmonary Medicine	PHYS	021	Pulmonary Diseases Physician	01
203BR0002Y	Physician/Osteopath Radiation Therapy	PHYS	401	Radiation Therapist	01
203BR0200Y	Physician/Osteopath Radiology	PHYS	400	Radiologist	01
203BR0200Y	Physician/Osteopath Radiology	PHYS	405	Special Procedures Radiologist*	01
203BR0200Y	Physician/Osteopath	PHYS	516	Radiology Consultant	01

HIPAA Taxonomy to CMAC Provider Class Mapping

HIPAA Code	HIPAA Provider Taxomony Codes and Descriptions	Provider Classification (KG-ADS)	CHCS Code	CHCS Provider Specialty Type Codes and Descriptions	CMAC Provider Class
	Radiology				
203BR0202Y	Physician/Osteopath Radiology, Diagnostic	PHYS	404	Diagnostic Radiologist	01
203BR0202Y	Physician/Osteopath Radiology, Diagnostic	PHYS	406	Radiology Resident	01
203BR0500Y	Physician/Osteopath Rheumatology	PHYS	020	Rheumatologist	01
203BS0100Y	Physician/Osteopath Surgery, General	PHYS	100	Surgeon, General	01
203BS0100Y	Physician/Osteopath Surgery, General	PHYS	108	Resident Surgeon	01
203BS0100Y	Physician/Osteopath Surgery, General	PHYS	508	Surgery Consultant	01
203BS0101Y	Physician/Osteopath Surgery, Colon & Rectal Surgery	PHYS	102	Colon & Rectal Surgeon	01
203BS0106Y	Physician/Osteopath Surgery, Hand: Orthopedic Surgery	PHYS	141	Hand Surgeon	01
203BS0110Y	Physician/Osteopath Surgery, Neurological	PHYS	106	Neurological Surgeon	01
203BS0113Y	Physician/Osteopath Surgery, Orthopedic	PHYS	140	Orthopedic Surgeon	01
203BS0113Y	Physician/Osteopath Surgery, Orthopedic	PHYS	142	Orthopedic Resident	01
203BS0113Y	Physician/Osteopath Surgery, Orthopedic	PHYS	512	Orthopedic Surgery Consultant	01
203BS0120Y	Physician/Osteopath Surgery, Pediatric	PHYS	104	Pediatric Surgeon	01
203BS0121Y	Physician/Osteopath Surgery, Plastic	PHYS	107	Plastic Surgeon	01
203BS0121Y	Physician/Osteopath Surgery, Plastic	PHYS	115	Plastic Surgery Resident	01
203BS0125Y	Physician/Osteopath Surgery, Thoracic	PHYS	101	Thoracic Surgeon	01
203BS0129Y	Physician/Osteopath Surgery, General Vascular	PHYS	105	Peripheral Vascular Surgeon	01
203BS0133N	Physician/Osteopath Surgery, Cardiovascular	PHYS	103	Cardiac Surgeon	01
203BU0100Y	Physician/Osteopath Urology	PHYS	110	Urologist	01
203BU0100Y	Physician/Osteopath Urology	PHYS	111	Urology Resident	01
203BU0100Y	Physician/Osteopath Urology	PHYS	509	Urology Consultant	01
203BU0300Y	Physician/Osteopath Underseas Medicine: Preventive Medicine	PHYS	322	Hyperbaric/Undersea Physician*	01
203BX0001Y	Physician/Osteopath Obstetrics & Gynecology	PHYS	150	Obstetrician & Gynecologist (OB/GYN)	01
203BX0001Y	Physician/Osteopath	PHYS	151	Endocrinologist, OB/GYN	01

HIPAA Taxonomy to CMAC Provider Class Mapping

HIPAA Code	HIPAA Provider Taxomony Codes and Descriptions	Provider Classification (KG-ADS)	CHCS Code	CHCS Provider Specialty Type Codes and Descriptions	CMAC Provider Class
	Obstetrics & Gynecology				
203BX0001Y	Physician/Osteopath Obstetrics & Gynecology	PHYS	154	OB/GYN Resident	01
203BX0001Y	Physician/Osteopath Obstetrics & Gynecology	PHYS	513	OB/GYN Consultant	01
203BX0100Y	Physician/Osteopath Occupational Medicine	PHYS	321	Occupational Medicine Physician	01
203BX0105Y	Physician/Osteopath Occupational-Environmental Medicine: Preventive Medicine	PHYS	91	Special Weapons Defense Physician*	01
203BX0105Y	Physician/Osteopath Occupational-Environmental Medicine: Preventive Medicine	PHYS	091	Special Weapons Defense Physician.	01
203BX0200Y	Physician/Osteopath Oncology	PHYS	013	Oncologist	01
203BX0201Y	Physician/Osteopath Oncology, Gynecologic	PHYS	152	Oncologist OB/GYN	01
203BX0300Y	Physician/Osteopath Ophthalmology	PHYS	120	Ophthalmologist	01
203BX0300Y	Physician/Osteopath Ophthalmology	PHYS	121	Ophthalmology Resident	01
203BX0300Y	Physician/Osteopath Ophthalmology	PHYS	510	Ophthalmology Consultant	01
203BX0500Y	Physician/Osteopath Otolaryngology	PHYS	130	Otolaryngologist	01
203BX0500Y	Physician/Osteopath Otolaryngology	PHYS	131	Otolarynology Resident	01
203BX0600Y	Physician/Osteopath Otorhinolaryngology	PHYS	511	Otorhinolaryngology Consultant	01
213E00000N	Podiatrist	DCP	707	Podiatrist	01
225100000N	Physical Therapist	DCP	706	Physical Therapist	04
225X00000N	Occupational Therapist	DCP	705	Occupational Therapist	04
231H00000N	Audiologist	DCP	709	Audiologist	04
235Z00000N	Speech-Language Pathologist	DCP	710	Speech Therapist	04
246QB0000N	Specialist/Technologist, Pathology Blood Banking	TECH	214	Blood Bank Officer	04
246QC1000N	Specialist/Technologist, Pathology Chemistry	TECH	213	Chemistry Lab Officer	04
246QH0600N	Specialist/Technologist, Pathology Histology	TECH	208	Histopathologist	04
246QM0900N	Specialist/Technologist, Pathology Microbiology	TECH	203	Medical Microbiologist	04
246QM0900N	Specialist/Technologist, Pathology Microbiology	TECH	212	Microbiology Lab Officer	04
246RM2200N	Technician, Pathology Medical Laboratory	TECH	210	Biomedical Lab Officer	04
246RM2200N	Technician, Pathology Medical Laboratory	TECH	211	Biomedical Lab Science Officer	04

HIPAA Taxonomy to CMAC Provider Class Mapping

HIPAA Code	HIPAA Provider Taxomony Codes and Descriptions	Provider Classification (KG-ADS)	CHCS Code	CHCS Provider Specialty Type Codes and Descriptions	CMAC Provider Class
246RM2200N	Technician, Pathology Medical Laboratory	TECH	215	Chemical Lab Officer, Other	04
246VC2400N	Specialist/Technologist Cardiology Cardiopulmonary-Cardiovascular	TECH	905	Cardiopulmonary Lab Technician	04
246ZS0400N	Specialist/Technologist, Other Surgical	TECH	109	Burn Therapist	04
2471R0003N	Radiologic Technologist Radiation Physicist	TECH	407	Radiophysicist	04
363A00000N	Physician Assistant	PA	901	Physician Assistant	04
363L00000N	Nurse Practitioner	APRN	610	Nurse, Clinical Nurse – Entry Level for Nurse Practitioner	04
363LP0200N	Nurse Practitioner Pediatrics	APRN	603	Pediatric Nurse Practitioner	04
363LP0808N	Nurse Practitioner Psychiatric/Mental Health	APRN	611	Psychiatric Nurse Practitioner	04
363LP2300N	Nurse Practitioner Primary Care	APRN	604	Primary Care Nurse Practitioner Qualified	04
363LP2300N	Nurse Practitioner Primary Care	APRN	605	Primary Care Nurse Practitioner - Entry	04
363LX0001N	Nurse Practitioner Obstetrics & Gynecology	APRN	602	OB/GYN Nurse Practitioner	04
366B00000N	Midwife, Certified	APRN	608	Certified Nurse Midwife	04
366B00000N	Midwife, Certified	APRN	609	Nurse Midwife - Entry Level	04
367500000N	Nurse Anesthetist, Certified Registered	APRN	094	Anesthetist	04
367500000N	Nurse Anesthetist, Certified Registered	APRN	612	Nurse Anesthetist	04

Outpatient Itemized Billing System Hold Periods

TPC Billing Hold Period/TPOCS	Duration of Time
OHI	3 - Days
ADM/Laboratory-Radiology	7 - Days **EXAMPLE: OHI/Coding completion (3 - Days) + ADM/Lab-Rad (7 - Days) = Total of 10 days before claim is sent to TPOCS for billing process**
Pharmacy	14 - Days **EXAMPLE: OHI/Coding completion (3 -Days) + Pharmacy (14 - Days) = Total of 17 days before claim is sent to TPOCS for billing process**
MSA Billing Hold Period/CHCS	**Duration of Time**
MSA	14 - Days **EXAMPLE: Coding completion (3-Days) + MSA Editing/Verification (14 - Days) = Total of 17 day billing hold period**

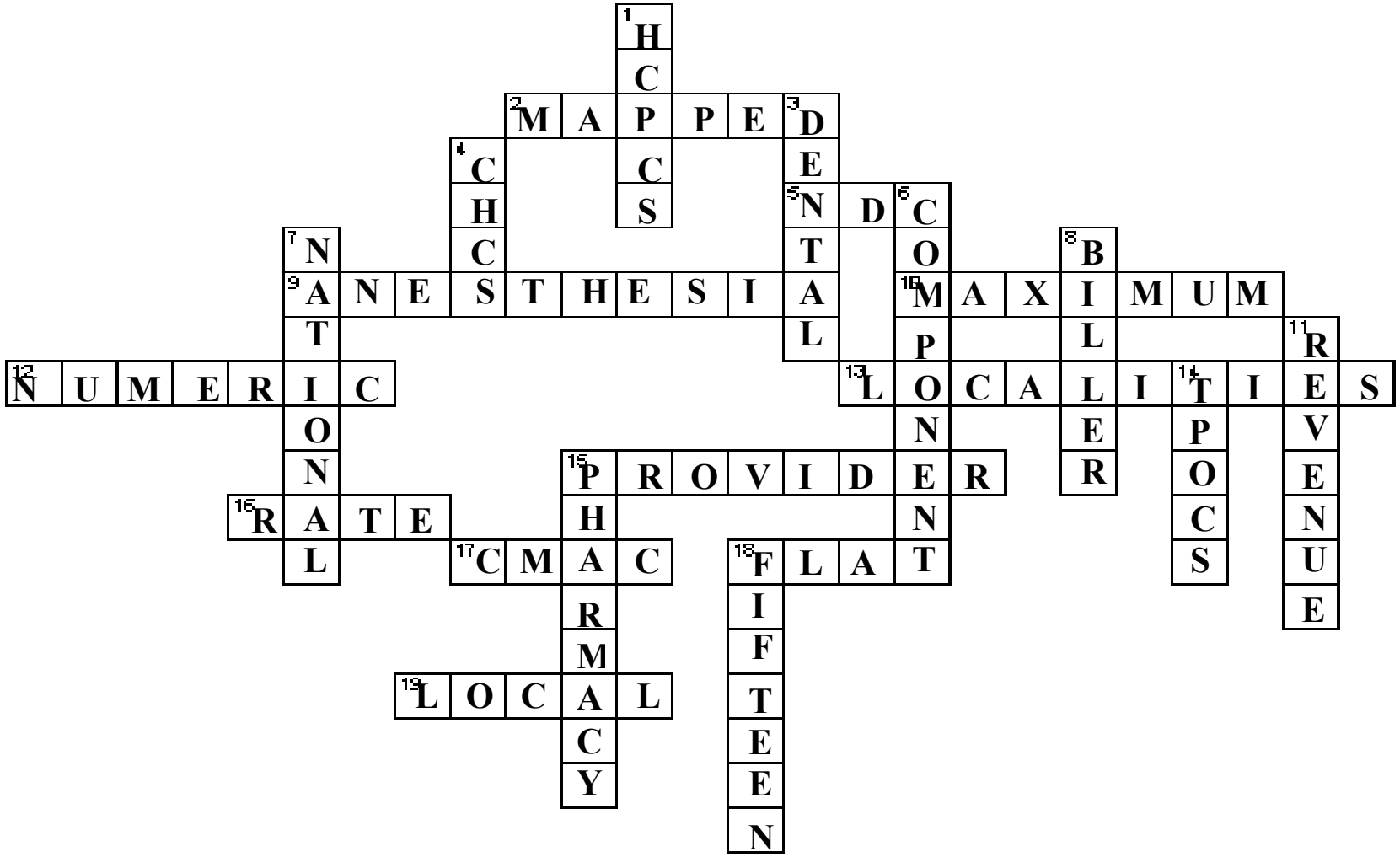
Rate Tables and Claim Form Selection

RATE TABLE	CPT/HCPCS CODES	CLAIM FORM
CMAC	99201 – 99499	CMS-1500
CMAC	10040 – 99199	UB-92 Note: If modifier 26 is used, then the code will print on the CMS-1500
Ambulance	A0999	UB-92
Anesthesia	00100 – 01999	CMS-1500
Dental	D0110 – D9440	ADA
DME/DMS	A4214 – A7509 E0100 – E2101 K0001 – K0051 L0100 – L8670 V2020 – V2780	UB-92
Immunizations/Injections	J0120 – J9999 90476 – 90799	UB -92
Pharmacy	NDC	UCF

Sample Revenue to CPT-4 Mapping

CODE	M		AMA SHORT DESC	RV1	RV2	RV3	RV4	RV5	RV6
00300	00	0030000	ANESTH, HEAD/NECK/PTRUNK	370	371	372	379	374	
11000	00	1100000	DEBRIDE INFECTED SKIN	360	450	510	500	509	
44320	00	4432000	COLOSTOMY	750	759	360	450	510	
51736	00	5173600	URINE FLOW MEASUREMENT	920	360	450	510	500	
75989	00	7598900	ABSCESS DRAINAGE UNDER X-RAY	320	350	359	402		
76380	26	7638026	CAT SCAN FOLLOW-UP STUDY	350	351	352	359		
76499	50	7649950	RADIOGRAPHIC PROCEDURE	320	322	324	350	610	
86185	00	8618500	COUNTERIMMUNOELECTROPHORESIS	302	300	390			
86255	00	8625500	FLUORESCENT ANTIBODY, SCREEN	302	300	390			
90632	00	9063200	HEP A VACCINE, ADULT IM	636					
90704	00	9070400	MUMPS VACCINE, SC	450	510	636			
90804	00	9080400	PSYTX, OFFICE, 20-30 MIN	910	911	914	915	916	
90922	00	9092200	ESRD RELATED SERVICES, DAY	510	840	850	880		
92004	00	9200400	EYE EXAM, NEW PATIENT	510	450				
92504	00	9250400	EAR MICROSCOPY EXAMINATION	441	444	510	471	450	
97001	00	9700100	PT EVALUATION	420	424				
97003	00	9700300	OT EVALUATION	430	434				
97110	00	9711000	THERAPEUTIC EXERCISES	420	430	440			
99140	00	9914000	EMERGENCY ANESTHESIA	370	371	372	374	379	
A0999	00	A099900	UNLISTED AMBULANCE SERVICE	540	542	543	545	549	
A4368	00	A436800	OSTOMY FILTER	270	272	274			
D2970	00	D297000	TEMPORARY- FRACTURED TOOTH	512	360	450	510		
E0100	00	E010000	CANE, ADJUSTABLE/FIXED, W/TIP	290	291	292	293	299	
E1590	00	E159000	HEMODIALYSIS MACHINE	840	843	849	290		
G0201	00	G020100	MOD/TRAIN, USE OF VOICE PROSTH	510	519				
J0150	00	J015000	INJECTION, ADENOSINE, 6 MG	636					
K0001	00	K000100	STANDARD WHEELCHAIR	290	291	292	293	299	
L0210	00	L021000	THORACIC, RIB BELT	274	290				
M0075	00	M007500	CELLULAR THERAPY	949	940				
P9038	00	P903800	RBC, IRRADIATED, EACH UNIT	380					
S0028	00	S002800	INJECTION, FAMOTIDINE, 20 MG	630					
V5244	00	V524400	HEARING AID, PROG, MON, CIC	510	470	479			

Coding & System Automation Review Crossword Puzzle



Coding & System Automation Review Crossword Puzzle

Across

2. Each CPT-4/HCPCS code is automatically _____ to a default revenue code.
5. Pharmacy rates are based on ____ numbers.
9. CPT-4 codes 00100-01999 are used for _____.
10. CMAC means CHAMPUS _____ ALLOWABLE CHARGE.
12. CPT-4 is a five-digit _____ code.
13. CMAC is organized by 90 different _____.
15. In addition to the CPT-4/HCPCS code, the CMAC rate is based on a _____ class.
16. CPT-4/HCPCS codes produce charges automatically from _____ tables.
17. Unlisted codes in _____ cannot be billed.
18. The anesthesia codes are based on a _____ rate.
19. Level III HCPCS are _____ codes.

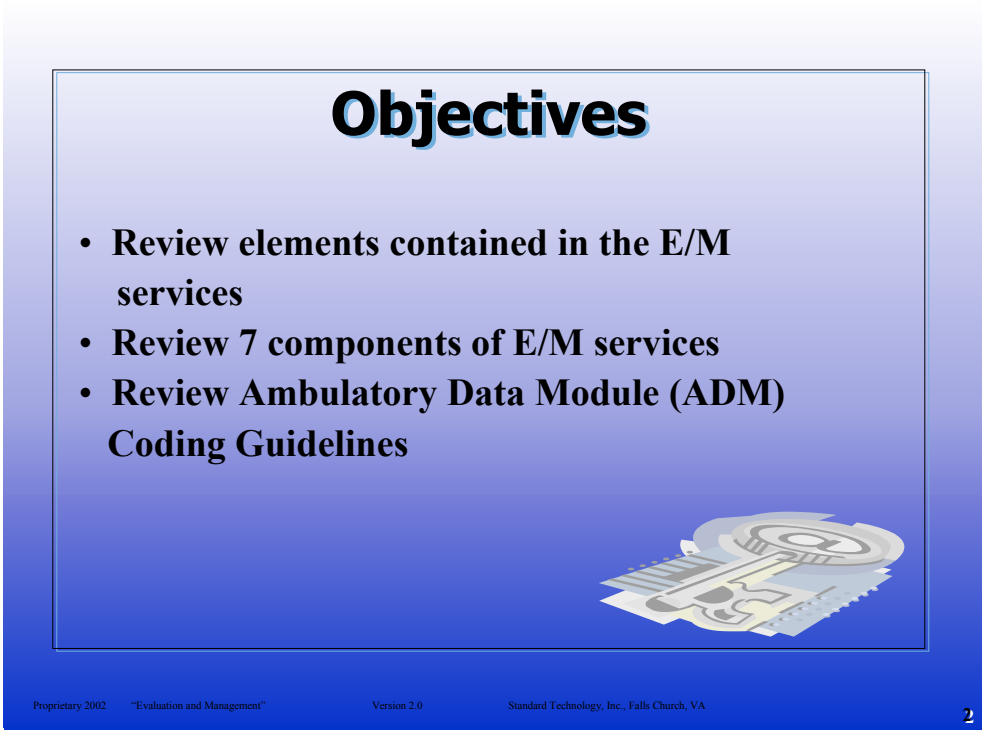
Down

1. Level I _____ are also CPT-4 codes.
3. The rate table for _____ is the ADT/CDT table.
4. This system will only have rates for its MTF.
6. The _____ rate table contains the rates for codes, which are broken down into Prof. and Tech. components.
7. Level II HCPCS are _____ codes.
8. Although claim form selection is a default process, the _____ has the ability to switch the claim.
11. _____ codes identifies a specific accommodation or ancillary charge on the UB-92 claim form.
14. Encounter data will be extracted from CHCS/ADM to _____.
15. Prescription costs are found on the NDC _____ rate table.
18. Ambulance charges are reimbursed at a flat rate in increments of _____ minutes.

Uniform Business Office
Outpatient Itemized Billing Training Course

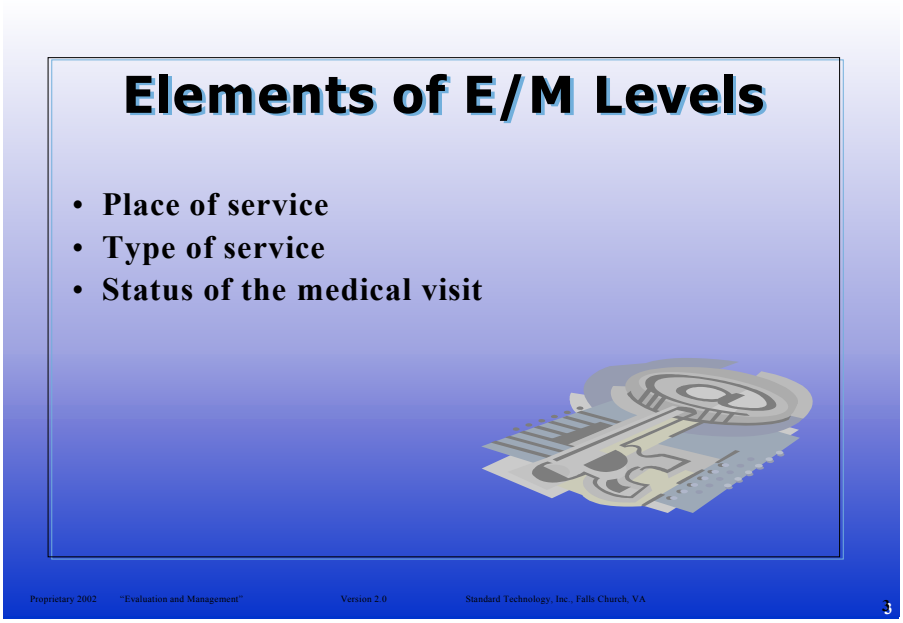
Evaluation & Management (E/M)

Proprietary 2002 "Evaluation and Management" Version 2.0 Standard Technology, Inc., Falls Church, VA



- This is an overview presentation of E/M and not a "How to code E/M" presentation.
- Selecting E/M codes is usually a function performed by a coder/provider.
- The billers will submit claims for the reimbursement of E/M services.
- E/M codes are structured to reimburse facilities for specific levels of care.
- Key components and supporting documentation are required to obtain specific levels of care.
- Currently, the May 1, 2000 ADM Coding Guidelines are used (formerly ADS/KG-ADS) **(THERE IS AN UPDATE IN PROGRESS)**

Note to Trainer: Have class refer to the Evaluation and Management Audit Sheet handout attached at the end of this presentation.



- E/M codes are found in the CPT-4 (Current Procedural Terminology) book and are also known as HCPCS (Healthcare Common Procedure Coding System) Level I codes.

- When selecting the appropriate E/M level, you must consider where the services were provided. Examples of locations can include:
  - clinics
  - hospitals
  - emergency room departments

- The type of service depends on the patient's illness or injury. Examples of types of service can include:
  - consultations
  - critical care

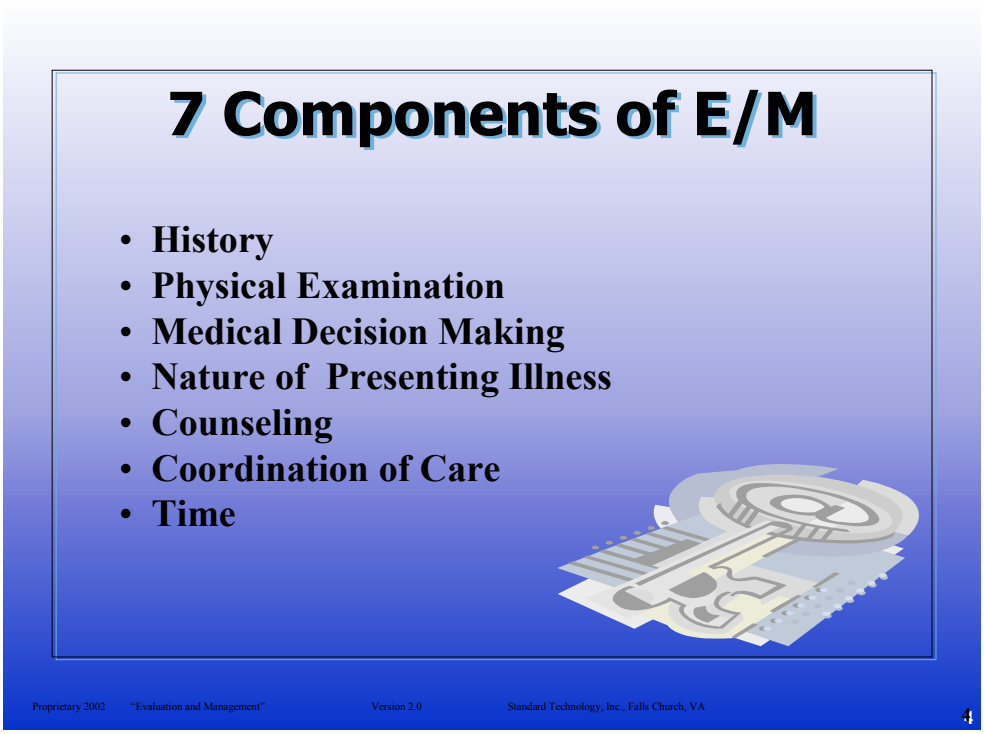
- The status of the medical visit refers to whether the patient is new or established.

- **A new patient is a patient:**
  - Who presents to a specific service/clinic at that facility for the first time; or
  - Who presents to a specific service/clinic at that facility for the first time in three years; and
  - Whose encounter meets the requirements of a visit.

  Example: A patient is seen in the Dermatology Clinic with red, itchy patches due to contact with poison ivy on the wrists and ankles. This is the patient's first encounter with this clinic for care, so he or she would be categorized as a new patient.

- **An established patient is a patient:**
  - Who was seen in a specific ambulatory service/clinic at that facility in the last three years; and;
  - Has received care from a privileged provider in a practice of one, or from any privileged provider in a group of providers of the same specialty; and
  - Whose encounter meets the requirements of a visit.

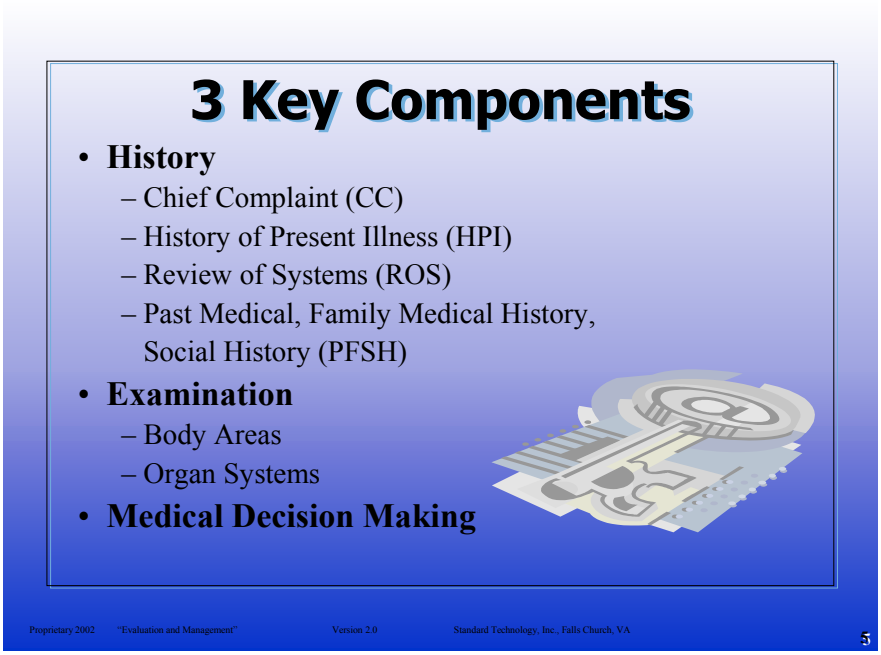
- **All of these elements contribute to selecting the proper E/M codes.**



• Components define levels of E/M.

• Although all seven Components may be used when selecting the appropriate E/M level, 3 key components that must be met:
  – History
  – Physical Examination and
  – Medical Decision Making

• The remaining E/M components are contributory and may or may not be met.



• If the patient is a new patient, <u>All 3 Key Components must be met</u>.

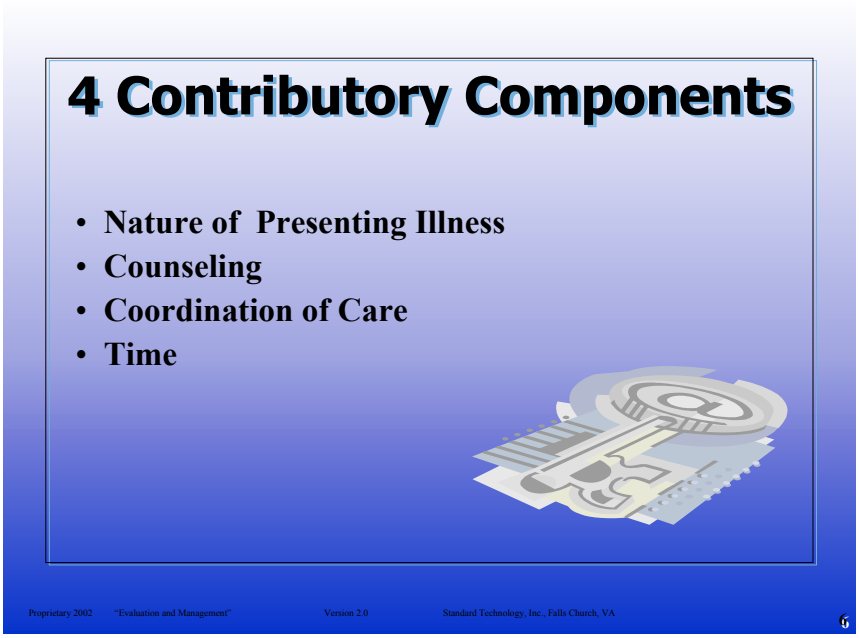
• When taking a **history** the provider must ask:
  – Chief complaint
  – History of the present illness, including the duration, location, severity, etc
  – Review of systems, including asking questions about weight loss, sinus problems, nausea, etc
  – Past medical, family medical and social history, including information such as past head trauma, marital status, history of family members having headaches, alcohol consumption, etc

• When performing a **physical examination** the provider must review:
  – Body areas, which include head, chest, neck, abdomen, back, genitalia and extremities
  – Organ systems, which include eyes, ears, nose, throat, cardiovascular, respiratory, neurological, etc

• When establishing a level of **medical decision making**:
  – The level is based on the complexity of establishing a diagnosis or selecting the appropriate management option. The four levels are straightforward, low complexity, moderate complexity, or high complexity.
  Example: If a patient is diagnosed with a sore throat, the medical decision making would be straightforward. If the same patient had a sore throat, fever and weight loss, then the medical decision making may be moderate, because the provider would have to determine the cause of the sore throat, fever and weight loss.

• With an established patient, two of three components must be met:
  – The physician may or may not complete one of the key components.
  Example: The provider may only perform a physical examination and establish a level of medical decision making.

• The E/M levels will vary depending on the overall complexity of the patient encounter.



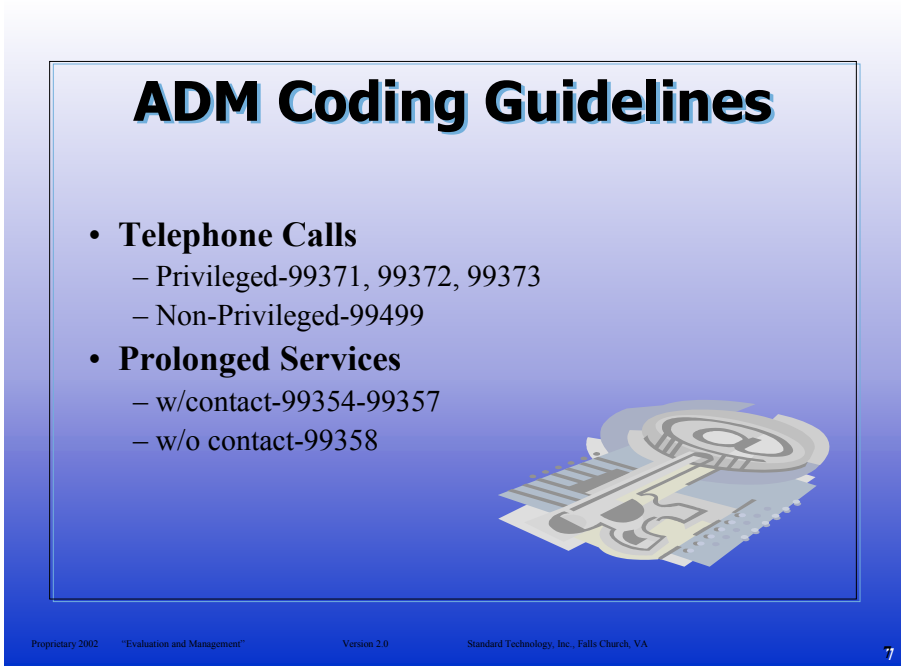
- Contributory components enhances the E/M level by presenting more detail and complexity to the decision making.

- Providing more detailed documentation will justify increasing the level of E/M resulting in greater reimbursement.

- **Nature of presenting illness** is:
  - Disease, condition, illness, injury, symptom, sign, finding, complaint or other reason for encounter, with or without a diagnosis being established at the time of the encounter
    Example: A female patient has chronic back pain and has never had any type of trauma or condition, that would explain her back pain. The pain usually starts in the middle of her back and radiates to her left side.
  - 5 types of nature of presenting illness:
    - Minimal, self-limited/minor, low severity, moderate severity and high severity. The previous example would constitute a self-limited or minor nature of presenting illness.
  - More specific information can be found in the current edition of the Current Procedural Terminology – 4th Edition book.

- **Counseling and coordination** of care may not be provided at every patient encounter. The complexity of the encounter is the most decisive factor in selecting the E/M level.

- If the key components have been met and the Counseling and Coordination of care takes up more than 50% of the total encounter time and the actual time is documented then **Time** becomes a factor in selecting the most appropriate level of E/M service:
  - Examples of Encounters:
    - Physician/patient and/or family encounter
    - Face to face in the office or outpatient setting



• These are a few services that are contained in the ADM Coding Guidelines. These services are telephone calls and prolonged services.

• Privileged providers may choose a telephone call code 99371, 99372 or 99373.

• Non-privileged providers engaged in telephone encounters with patients may document their services using E/M code 99499, when applicable.

• The code range 99354-99357 should be used when patients require an unusual amount of face-to-face, privileged provider time.

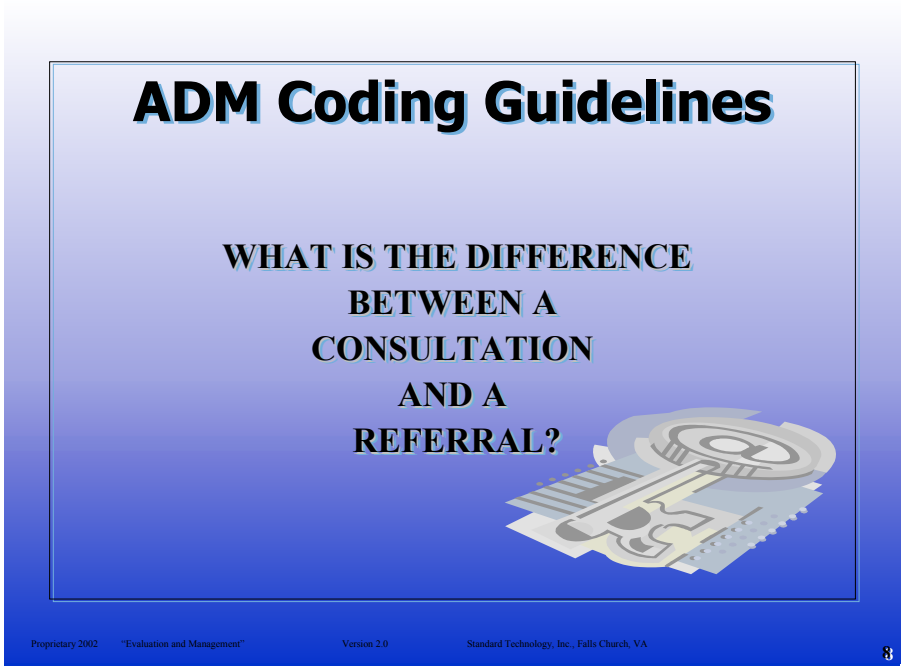
• Prolonged services must be clearly documented in the patient record along with the amount of time that the service was provided.

• Under these circumstances, the prolonged service code will be used in conjunction with other E/M codes.

•At this time, only one E/M can be entered in CHCS.

• The code 99358 will be used to collect data regarding time spent not in the patient's presence, before or after direct (face to face) services.

Note to Trainer: What is the difference between a privileged and non-privileged provider?
– A **privileged provider** is essentially an independent practitioner who is granted permission to provide medical, dental and other patient care in the granting facility within defined limits, based on the individual's education, professional license, experience, competence, ability, health and judgment. **Non-privileged providers** are normally restricted to using E/M code 99211 to document face-to-face encounters in ADM.

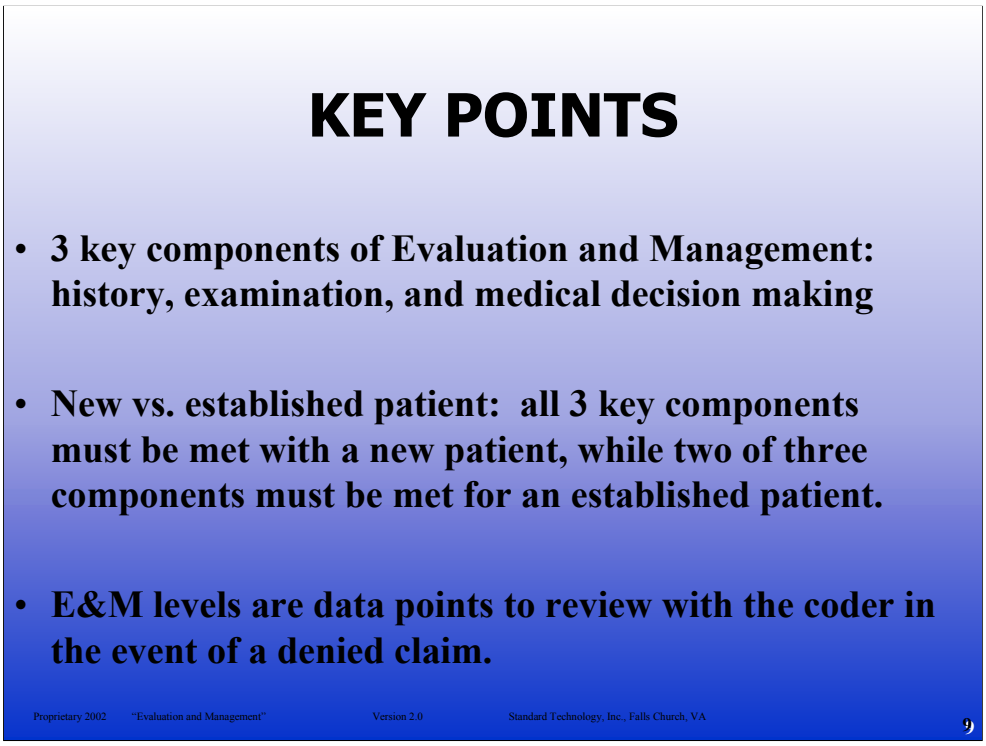


- A **consultation** occurs when a physician provides an opinion or advice regarding a certain patient at the request of a privileged provider. Consultations are **"evaluate and return"** whereby the patient remains in the care of the provider requesting the consultation. Consultations are frequently confused referrals.

  – A consultation may be more than one visit. A consultation continues until a definitive diagnosis is made and treatment begins.
  – The AMA and CMS use the following criteria to define a consultation:

    - The consultation is **requested by another privileged provider or source** such as third party payer.
    - The consultant **renders an opinion or advice.**
    - The consultant **initiates diagnostic or therapeutic services.**
    - The requesting provider has **documented** the request and the need for the consultation in the **patient record.**
    - The consultant's opinion, advice and any services rendered are documented in the patient record and communicated to the requesting provider or source, generally in the form of a written report in accordance with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards.

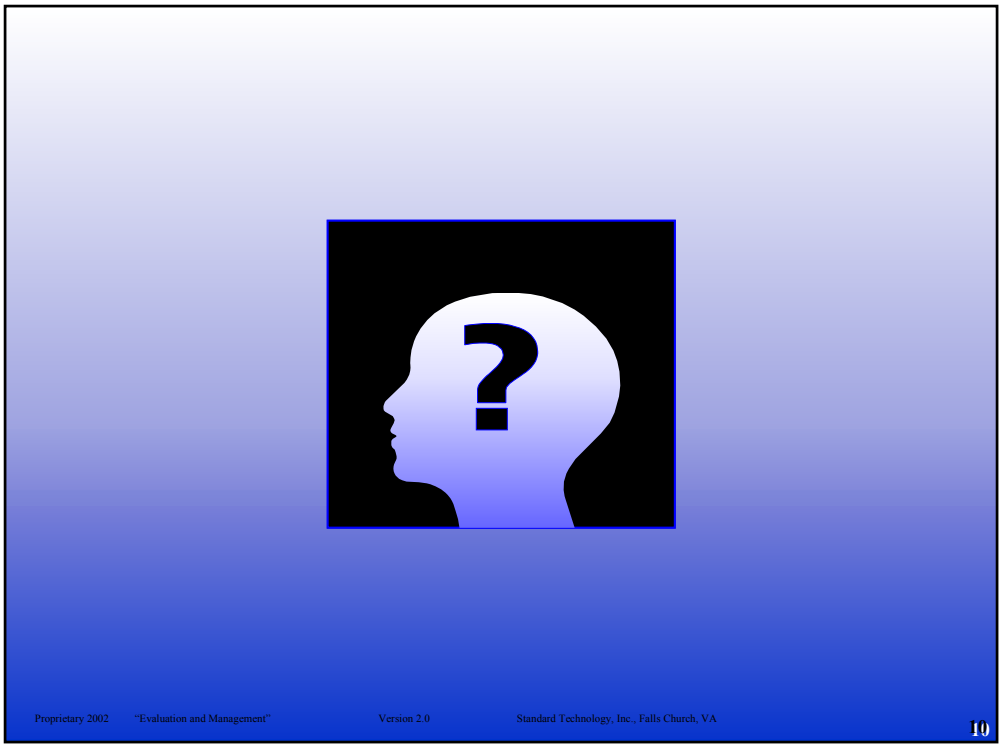
- A **referral** is when a physician transfers control of the patient's care to a second physician in another specialty. Referrals are **"evaluate and treat."** Referrals are coded using E/M codes for office visits as the new provider assumes full control of the patient.



• It is important to remember that with outpatient itemized billing, the entire coding process will become more complex.

• Providers will code encounters at a more complex level than required in the past.

  – More than one E/M is possible
  – There can be numerous diagnosis and procedure codes
  – There will be two or more claim forms produced for each encounter



• You may reference the ADM Coding Guidelines and the UBO website at www.tricare.osd.mil.

•Are there any questions?

Patient Name Brown, Larry **Charges Submitted** 23MAR02 **DOS** 3 23 02 **DR..NP..PA** Jones **Account Number** A02-3721

History (3 of 3)

HPI X Location ___Duration ___Signs & Symptoms ___Severity ___Modifying Factors ___Context ___Timing ___Quality
Brief (1-3) Extended(4+ elements or 3+ Chronic Illnesses)

ROS ___Allerg. ___Const. X ENT ___Eyes ___CV ___Resp. ___Integ. ___GI ___GU ___Musc. ___Heme/Lymph ___Neuro ___Endocrine ___Psych
N/A Problem Pertinent(1) Extended(2-9) Complete (10+)

PFSH ___Past History ___Family History ___Social History
N/A Problem Pertinent(1) Complete (3 of 3)

Type of History: (Problem Focused) Expanded Problem Focused Detailed Comprehensive

Examination

Constit. ____ 3
* 3 or more vitals: 1) Sit or Stand BP 2) Supine BP 3) Pulse Rate/Regularity 4)Respiration 5) Temperature 6) Height 7) Weight
* General Appearance of Patient(development, nutrition, body habitus, deformities)

Eyes ____
* Inspection of conjunctivae and lids
* Examination of pupils and irises (reaction to light and accommodation, size and symmetry)
* Opthalmoscopic examination of optic discs (size, C/D ratio, appearance) and posterior segments (vessel changes, exudates, hemorrhages)

Ears, Nose, Mouth & Throat ~~3~~
* External inspection of ears and nose (overall appearance, scars, lesions, masses)
* Otoscopic examination of external auditory canals and tympanic membranes
* Assessment of hearing (whispered voice, finger rub, tuning fork)
* Inspection of nasal mucosa, septum and turbinates
* Inspection of lips, teeth and gums
* Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx

Neck ____
* Examination of Neck(masses, appearance, symmetry, tracheal position, crepitus)
* Examination of thyroid (enlargement, tenderness, mass)

Lymph ____
Palpation of lymph nodes in 2 or more areas:
* Neck
* Axillae
* Groin
* Other

Resp. ____
* Assessment of respiratory effort (intercostal retractions, use of accessory muscles, diaphragmatic movement)
* Percussion of chest (dullness, flatness, hyperresonance)
* Palpation of chest (tactile fremitus)
* Auscultation of lungs (breath sounds, adventitious sounds and rubs)

CV ____
* Palpation of heart (location, size, thrills)
* Auscultation of heart with notation of abnormal sounds and murmurs

Examination of:
* carotid arteries (pulse amplitude, bruits)
* abdominal aorta (size, bruits)
* femoral arteries (pulse amplitude, bruits)
* pedal pulses (pulse amplitude)
* extremities for edema and/or varicosities

GI (Abd.) ____
* Examination of abdomen with notation of presence of masses or tenderness
* Examination for presence or absence of hernia
* Examination of liver and spleen
* Examination of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses
* Obtain stool sample for occult blood test when indicated

Chest-Breast ____
* Inspection of breasts (symmetry, nipple discharge)
* Palpation of breasts and axillae (masses or lumps, tenderness)

GU ____
MALE:
* Examination of the scrotal contents (hydrocele, spermatocele, tenderness of cord, testicular mass)
* Examination of the penis
* Digital rectal examination of prostate gland (size, symmetry, nodularity, tenderness)

FEMALE:
Pelvic examination(with or without specimen collection for smears and cultures) including:
* Examination of external genitalia (general appearance, hair distribution, lesions) and vagina (general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
* Examination of urethra (masses, tenderness, scarring)
* Examination of bladder (fullness, masses, tenderness)
* Cervix (general appearance, lesions, discharge)
* Uterus (size, contour, position, mobility, tenderness, consistency, descent or support)
* Adenxa/parametria (masses, tenderness, organomegaly, nodularity)

Musc. ____
* Examination of gait and station
* Inspection and/or palpation of digits and nails (clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)

Examination of joints, bones and muscles of one or more of the following six areas:
1) head and neck 2) spine, ribs and pelvis 3) Rt UE 4)Lt UE 5) Rt LE 6)Lt LE
The examination of a given area includes:
* Inspection and/or Palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions
* Assessment of range of motion with notation of any pain, crepitation or contracture
* Assessment of stability with notation of any dislocation, subluxation or laxity
* Assessment of muscle strength and tone (flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements

Skin ____
* Inspection of skin and subcutaneous tissue (rashes, lesions, ulcers)
* Palpation of skin and subcutaneous tissue (induration, subcutaneous nodules, tightening)

Neuro ____
* Test cranial nerves with notation of any deficits
* Examination of deep tendon reflexes with notation of pathological reflexes(Babinski)
* Examination of sensation (by touch, pin, vibration, proprioception)

Psych ____
* Description of patient's judgement and insight

Brief assessment of mental status including:
* Orientation to time, place, and person
* Recent and remote memory
* Mood and affect (depression, anxiety, agitation)

Type of Exam: Problem Focused Expanded Problem Focused Detailed Comprehensive

Medical Decision Making

	Number of Diagnoses and/or Risk of Complications		Management Options Selected
MINIM ____	* One self-limited or minor problem: contusion, insect bite, tinea corporis	**MINIM** ____	* Rest, Gargles * Elastic bandages, superficial dressings
LOW ____ 1	* One or two self-limited problem(s) or symptom(s) * One stable chronic illness * Acute self-limited uncomplicated illness or injury * Risk of complications, morbidity or mortality is low	**LOW** ____	* Rest * Over-the-counter drugs * Medication management with minimal risk * Referrals not requiring detailed discussion or detailed care plan
MOD ____	* Three or more or self-limited problems * One or more chronic problems with mild to moderate exacerbation, progression or side effects of treatment * Two or three stable chronic illnesses * Undiagnosed new illness, injury or problem with uncertain prognosis * Acute illness with systemic symptoms * Risk of complications, morbidity or mortality is moderate. There may be an uncertain prognosis or the possibility of prolonged functional impairment with or without treatment.	**MOD** ____	* Referrals requiring detailed discussion or detailed care plan * Management of medications with moderate risk requiring detailed discussion, detailed assessment for side effects, or limited laboratory monitoring * Arranging hospitalization for noncritical illness/injury * Surgery or procedure with ASA I risk status * Discussion for psychotherapy and/or counseling * Initiation of total parenteral nutrition * Referral for comprehensive pain management rehabilitation
HIGH ____	* One or more chronic illnesses with severe exacerbation, progression, side effects * Four or more stable chronic illnesses **AMA suggested revision * Acute complicated injury with significant risk of morbidity or mortality * Acute or chronic illnesses that pose a threat to life or bodily function * Abrupt change in bodily function (e.g., seizure, CVA, acute mental status change) * Risk of complications, morbidity/mortality is high. Possibility of sig. prolonged impairment	**HIGH** ____	* Emergency hospitalization * Medications requiring intensive monitoring, bearing untoward risks of serious morbidity if adverse effects occur * Surgery or procedure with ASA 2* or higher risk status * Decision not to resuscitate or to de-escalate care because of poor prognosis * Mechanical ventilator management

Type of Medical Decision Making: MINIMAL (LOW) MODERATE HIGH

Documentation supports an E/M charge of 99212.

Date:	Name:	DOB:
23MAR02	**Brown, Larry**	**06JUN95**

Chief Complaint:
Left ear pain

Wt:	BP:	P:	T:	R:	Ht:
40		**99.8**		**3'5"**	

1 **HPI:** Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Signs/Symptoms, Status of Chronic Illnesses

Pain left ear X 2 days
History of ear infections, since birth.

ROS:	Systemic	ENT	Eyes	Lymph	Resp	CV	GI	GU	Skin	MS	Endo	Neuro	Psych	Allerg
+	2	3	4	5	6	7	8	9	10	11	12	13	14	15
–		+												

16 [x] All other ROS negative

Past, Family, Social History

Active 6 year old w/ a history of ear infections

18 **PH:** [x] No change since _____ 19 **FH:** [ ] No change since _____ 20 **SH:** [x] No change since _____

EXAMINATION:

		NI	Ab
General Appear	21	☐	☐
Eyes			
Conjunctiva, lids	27	☐	☐
Pupils, irises	28	☐	☐
Optic disc, post seg	30	☐	☐
ENT			
Ext ears, nose	41	☐	☒
Auditory canals, TM:	42	☐	☒
Hearing	43	☐	☐
Mucosa, septum	44	☐	☐
Lips, teeth, gums	45	☐	☐
Oropharynx, tonsils	48	☐	☒
Neck			
Mass, trachea	52	☐	☐
Thyroid	53	☐	☐

		NI	Ab
Respiratory			
Effort	55	☐	☐
Auscultation	56	☐	☐
Percussion	57	☐	☐
Chest palpation	58	☐	☐
Heart			
Palpation	61	☐	☐
Auscultation	62	☐	☐
Carotid	63	☐	☐
Abdominal Ao	64	☐	☐
Femoral pulse	65	☐	☐
Pedal pulse	66	☐	☐
Edema	67	☐	☐
Abdomen / GI			
Mass, tender	70	☐	☐
Liver, spleen	71	☐	☐
Hernia	72	☐	☐
Stool OB	73	☐	☐
Anus, rectal	74	☐	☐

		NI	Ab
Breasts			
Symmetry, dc	76	☐	☐
Mass, tender	77	☐	☐
Male			
Penis	81	☐	☐
Testes, etc	85	☐	☐
Prostate	86	☐	☐
Female			
Ext genitalia	91	☐	☐
Urethra	84	☐	☐
Bladder	92	☐	☐
Cervix	94	☐	☐
Uterus	95	☐	☐
Adnexa	96	☐	☐
Lymphatic			
Neck	97	☐	☐
Axilla	98	☐	☐
Groin	99	☐	☐
Other	100	☐	☐

		NI	Ab
Musculoskeletal			
Gait, station	102	☐	☐
Digits, nails	103	☐	☐
Inspect, palpate	104	☐	☐
Range of motion	105	☐	☐
Stability	106	☐	☐
Strength, tone	107	☐	☐
Skin			
Inspection	136	☐	☐
Palpation	137	☐	☐
Neurologic			
Cranials 2-12	152	☐	☐
DTR	153	☐	☐
Sensation	154	☐	☐
Psychiatric			
Judgement	156	☐	☐
Orientation x 3	169	☐	☐
R, R memory	170	☐	☐
Mood, affect	171	☐	☐

Abnormal PE Findings:

External ear wnl, but has redness. Left ear red w/ no supporation.

Diagnostic Results:

Otitis Media

Impression:

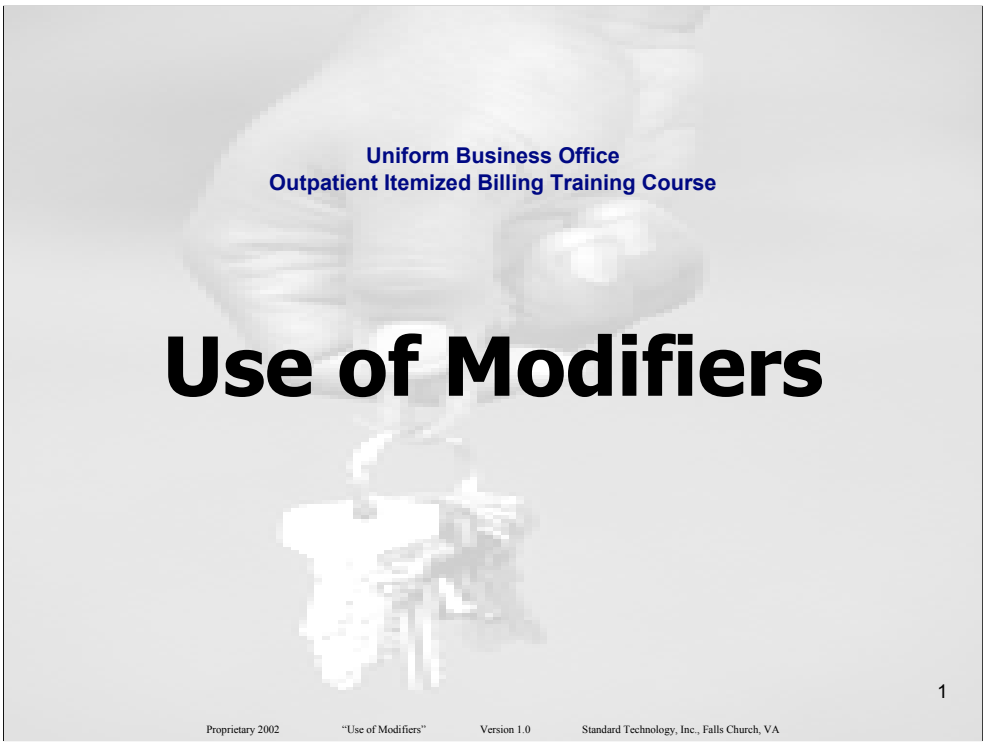
Acute Otitis Media

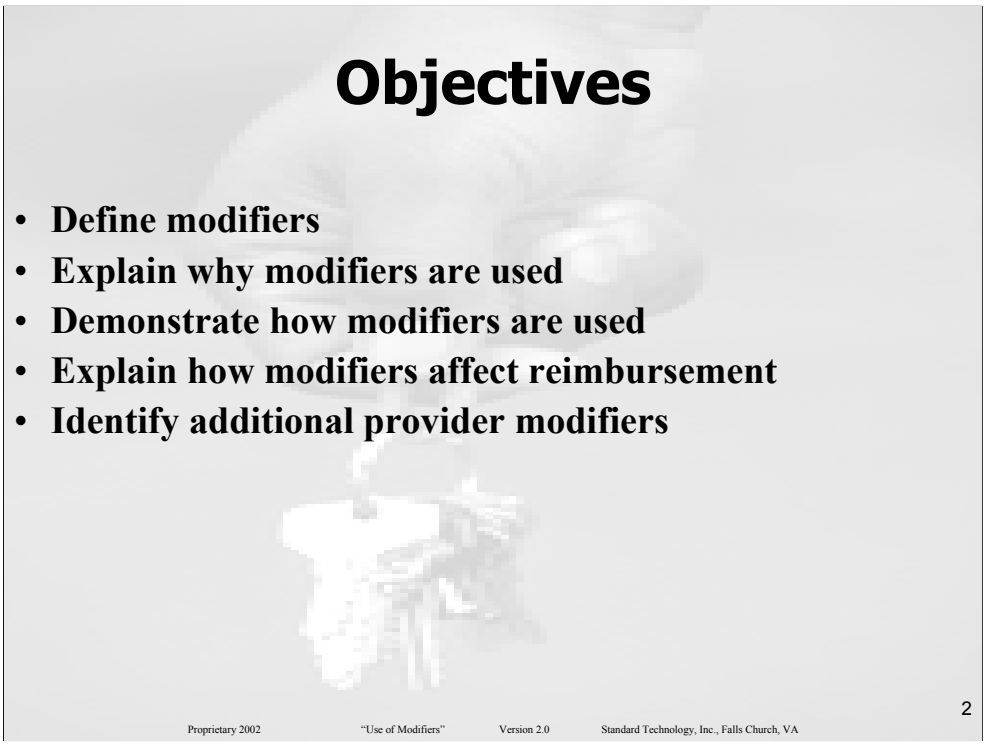
Assessment & Plan:

Dx: AOM **Status:** **Rx/Tx/Management:**

Amox 250mg x 1/2 tsp. t.i.d

Signature: Benz, Jones MD Date: 23MAR02


Uniform Business Office
Outpatient Itemized Billing Training Course
Use of Modifiers
1
Proprietary 2002 "Use of Modifiers" Version 1.0 Standard Technology, Inc., Falls Church, VA



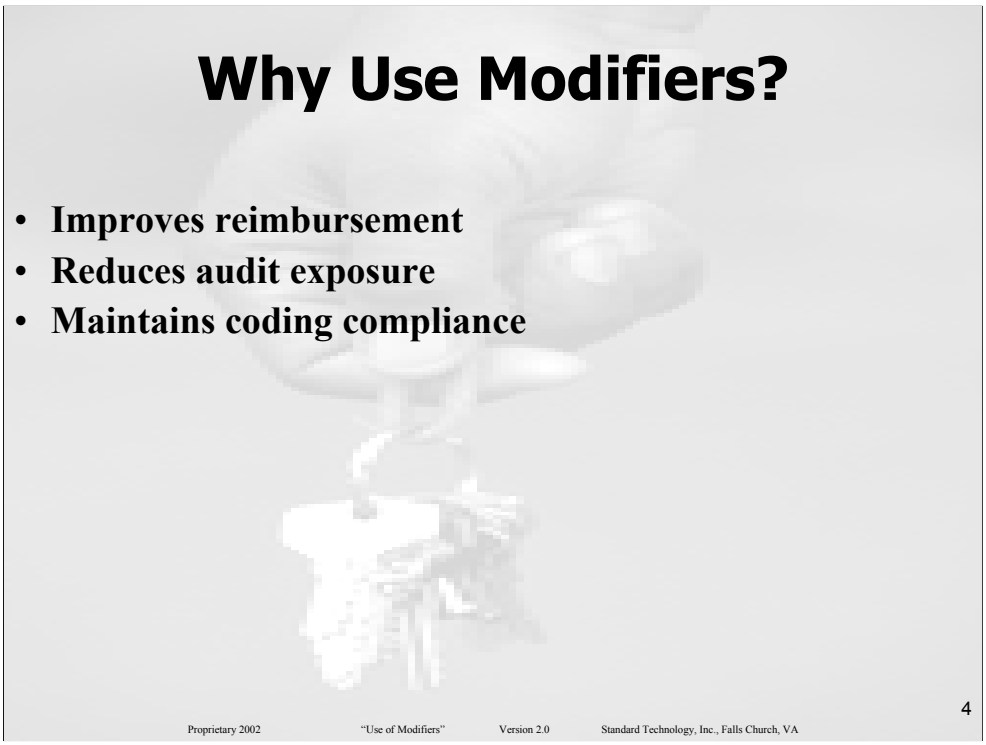
- This presentation on Modifiers is a broad overview on:
  - **What** they are
  - **Why** use them
  - **How** to use them
  - **How they apply** to Outpatient Itemized Billing

- **Note:** Keep in mind that these codes will appear automatically on the itemized claim. Therefore, no manual intervention is required.

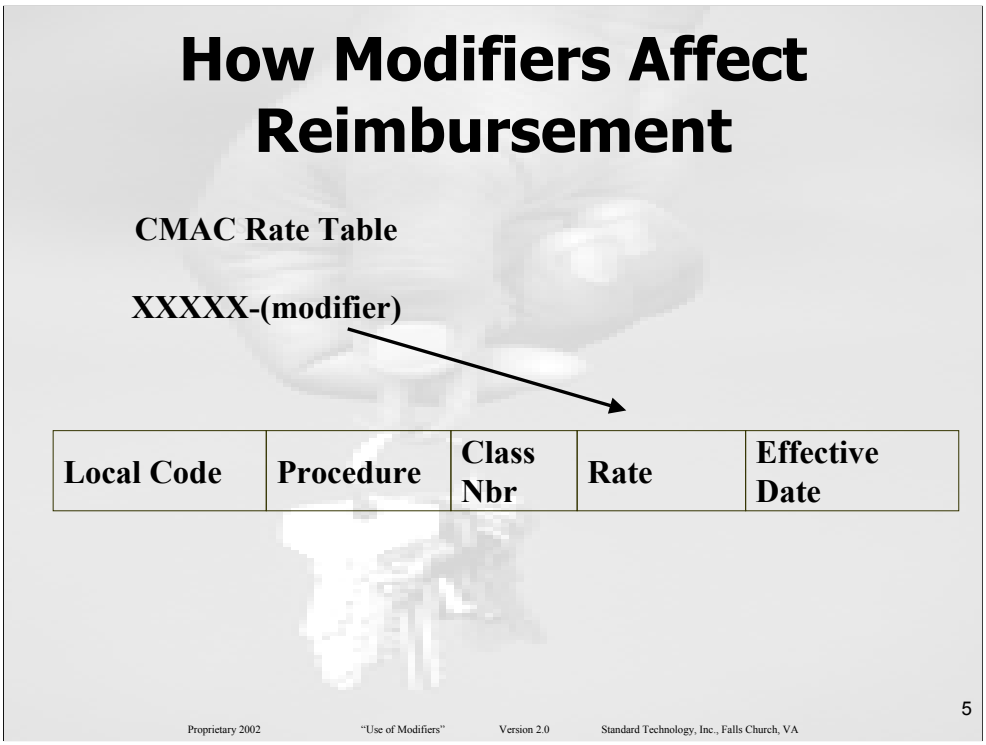
- **Note to Trainer:** Have class refer to the CPT-4/HCPCS to Modifier mapping example attached at the end of this presentation.

What Are Modifiers?

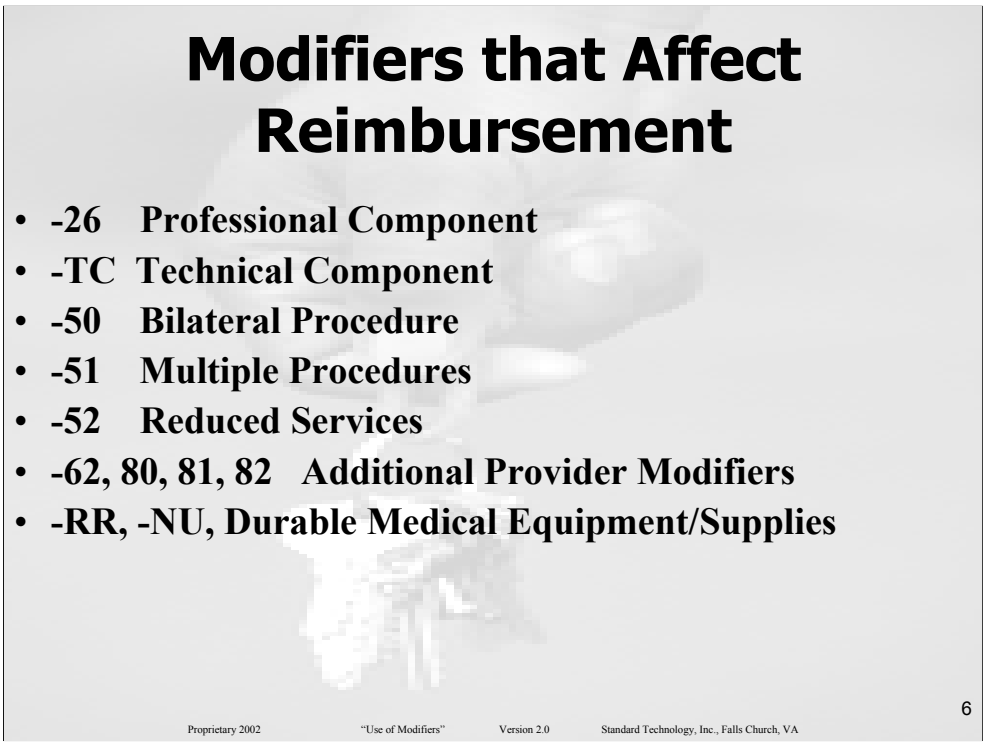
- Two-digit adjectives
- Additional information that is not part of the CPT-4/HCPCS code description
- Numeric, alpha-numeric, or alpha



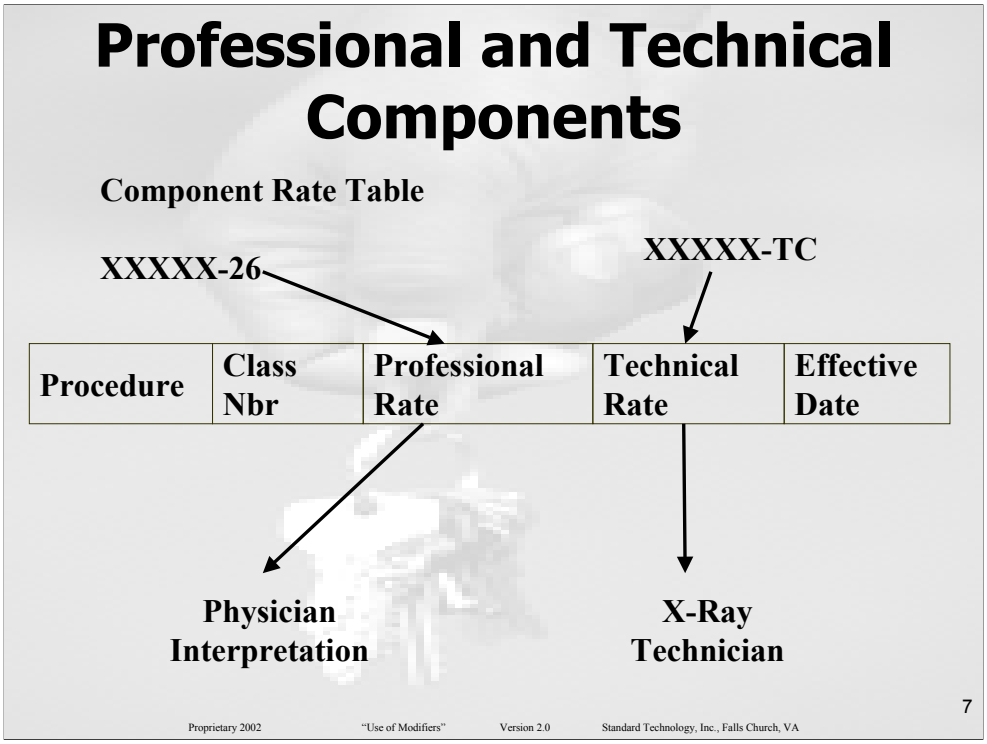
- There are several reasons to use modifiers. When applicable, modifiers:
  - **Improves reimbursement**
    - Without the use of modifiers indicating multiple procedures, CPT-4/HCPCS can only be reported once.
    - The payer will assume it is a duplicate charge and will decrease reimbursement.
  - **Reduces audit exposure**
    - Without the use of a modifier, the payer may see a pattern of duplicate charges and may begin auditing the MTF.
  - **Maintains coding compliance**
    - The use of modifiers provides more detail about services rendered.



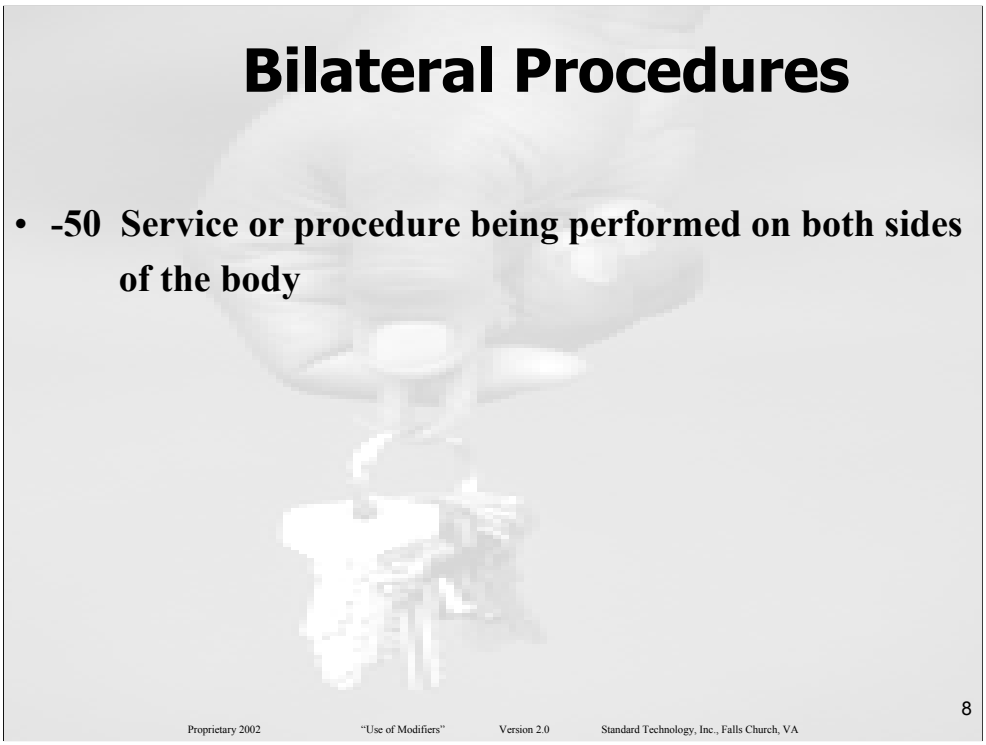
- Modifiers will be used to pull rates from the CHAMPUS Maximum Allowable Charge (CMAC) Table.
- The CMAC tables are located in both CHCS and TPOCS.
- The system (either CHCS or TPOCS) will read the CPT-4/HCPCS code and point to the CMAC table to obtain the rate (regardless of what the modifier is, **in most cases**).
- Modifiers are used to "clarify" the scope of services provided or the circumstances under which the services were provided and/or delivered.



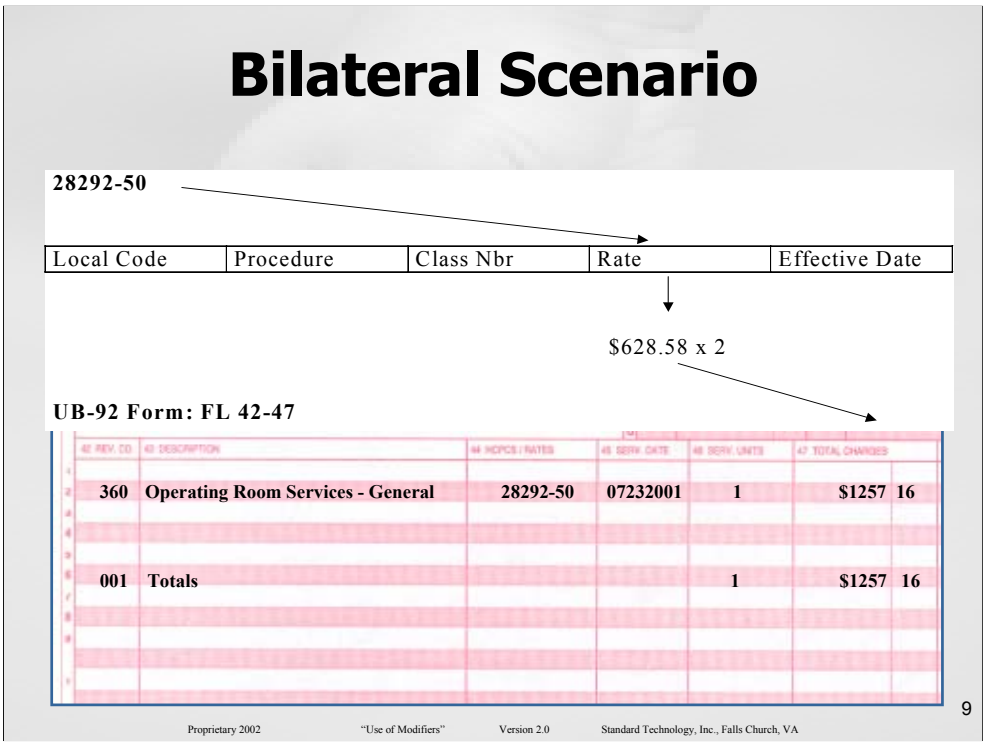
- These modifiers affect the reimbursement rate:
  - Modifier -52
    - Indicates that the physician elected to reduce or eliminate a portion of a service or procedure.
    - This modifier does not affect or change the rate that is put on the claim form.
    - It will be up to the payer to decide how much to reduce the payment.



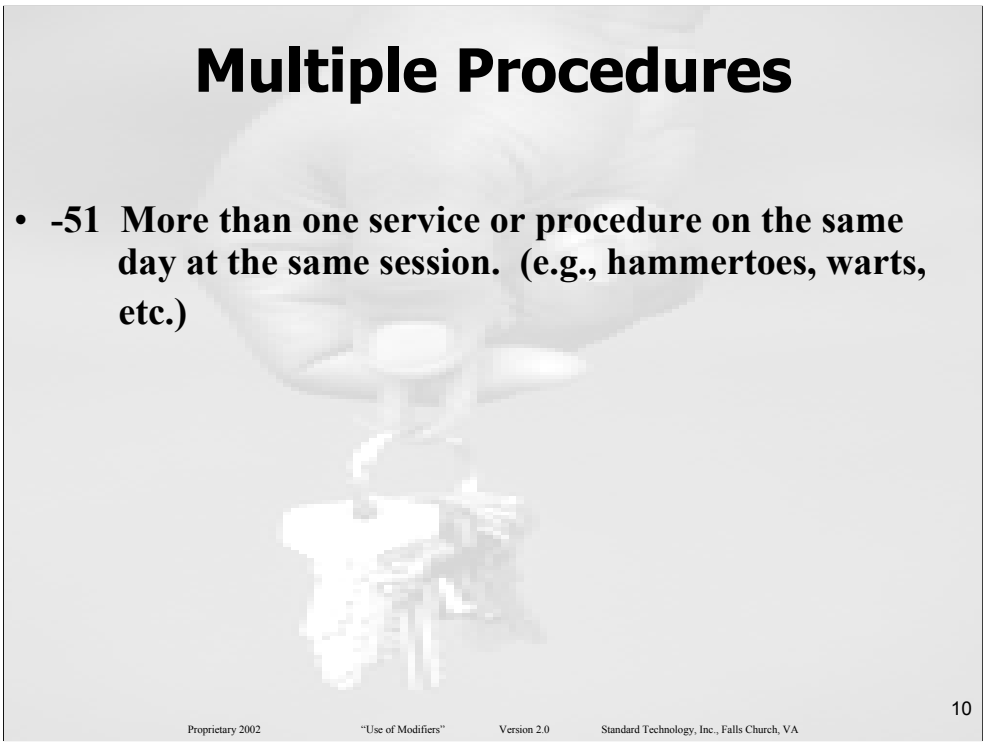
- CMAC utilizes several table formats. This slide depicts the component rate table which has rates for the technical and professional components of a CPT-4/HCPCS code.
- - 26 and -TC modifiers separate the professional and technical components of CPT-4/HCPCS codes, often used in the radiology and laboratory services.
  - For example, a patient may be sent to get an X-ray. The X-ray technician takes the X-ray and sends it back to the physician for the interpretation.
    - The services of the X-ray technician would be coded with the CPT-4 code and the modifier –TC:
      - The system populates this modifier on the UB-92 Claim Form.
    - The physician's interpretation of the X-ray would be coded with the same CPT-4 code as the X-ray technician but with the modifier -26 added.
      - The system populates this modifier on the CMS-1500 Claim Form.



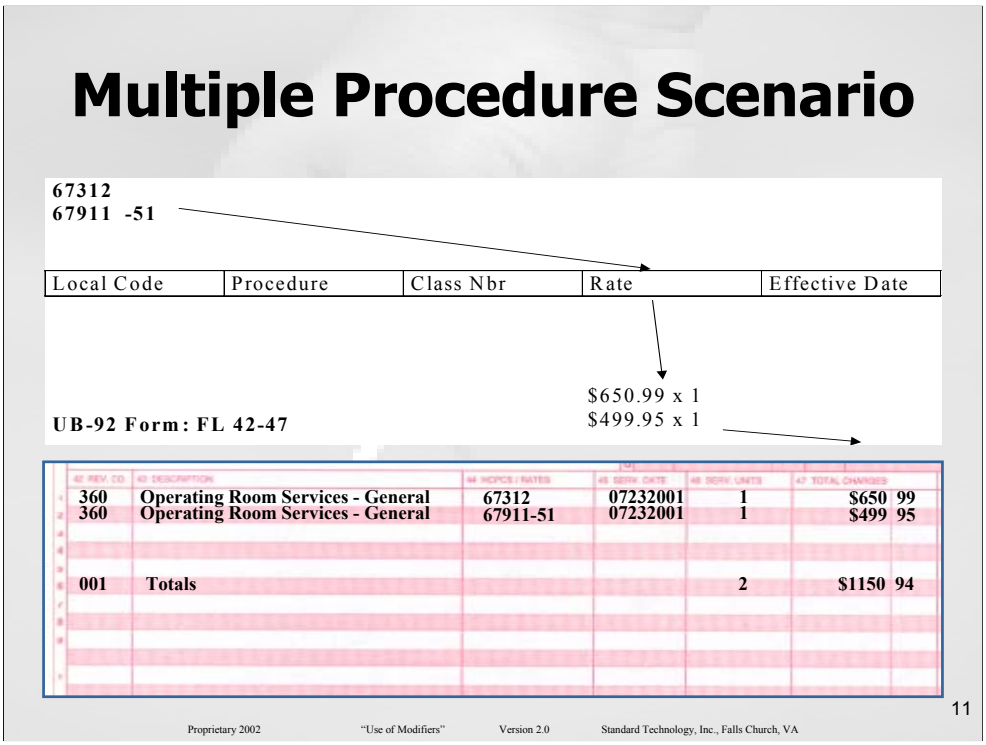
- Modifier -50 indicates that the procedure was performed twice on the same body site, both sides of the body during the same visit.
- The CPT-4 would be coded only once with modifier -50.
- The system will automatically double the charge.
- If one procedure is performed on the **left** and a different procedure (different CPT-4) is performed on the **right:**
  - The bilateral modifier **should not be used.**
  - Both CPT-4 codes **should be reported.**



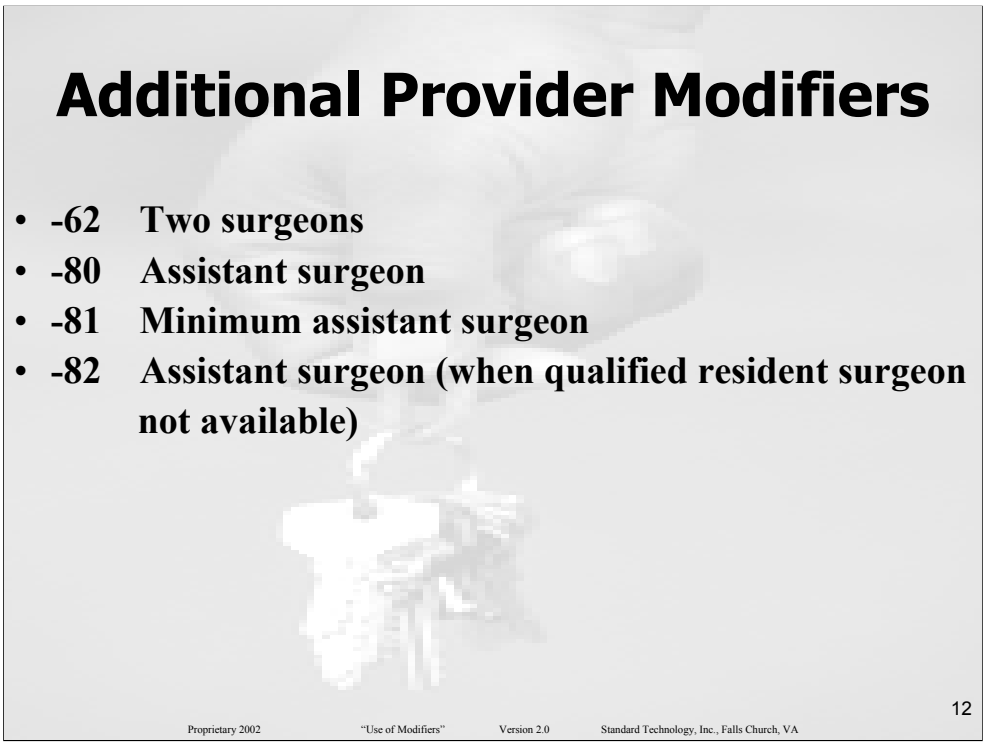
- For example, a patient presented to the clinic with chief complaint of pain in both feet. Patient was diagnosed with hammertoes in the great toe of both the left and right foot. Correction of the hammertoes was performed.
- The procedure was coded with CPT-4 code 28292.
- Modifier -50 is added to signify that the same procedure was performed at the same body site (opposite side of the body a second time (bilateral)).
- This is reported only as a **single** line item.
- The system will read modifier -50 and point to the CMAC rate table, pull the rate and automatically double it.
- In this example, the rate of $628.58 was pulled and doubled.
- Note that in FL 46, the service units is listed as "1" since the modifier -50 designates a bilateral procedure.



- The use of the modifier -51 indicates a procedure performed more than once during the same visit to multiple body sites and/or different procedures on the same body site.



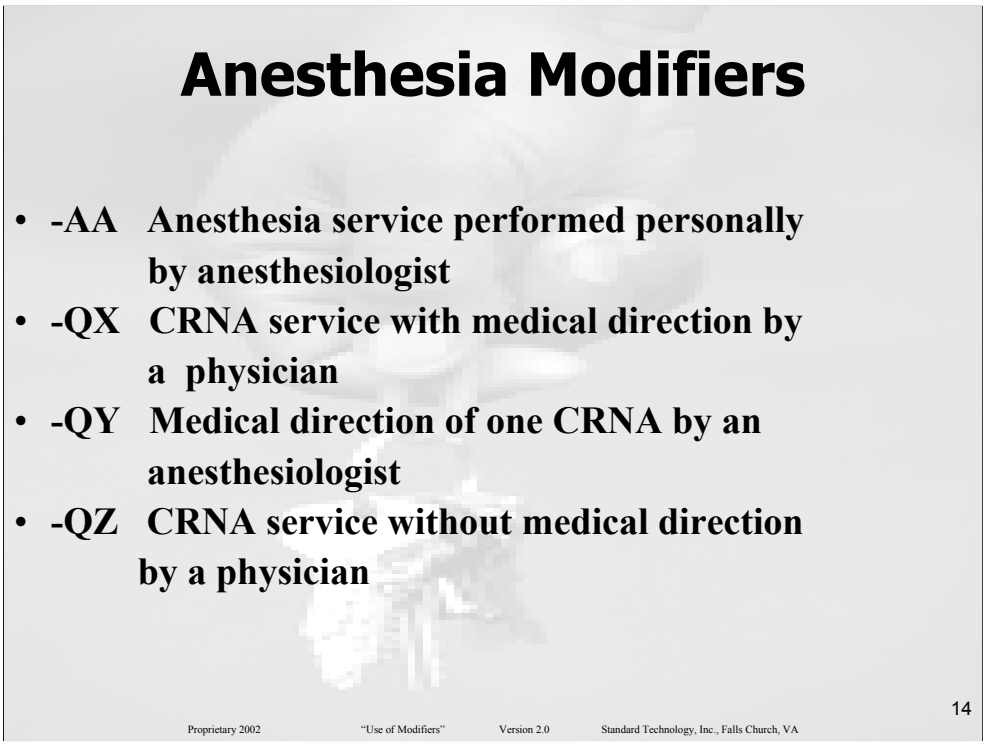
- For example, the ophthalmologist repairs two horizontal muscles for Alternating Esotropia (378.05), and a Lid Retraction Repair (374.41) in an outpatient setting. The billing would be submitted as follows:
  - The first line item was coded with **67312** (Strabismus surgery, recession or resection procedure, two horizontal muscles)
  - The second line item was coded with **67911 –51** (Correction of lid retraction, -Multiple Procedure)
  - The system will automatically find the rate and apply it to the claim form appropriately.



- Use of these modifiers will trigger the system to generate additional claim form(s).
- If a second provider is listed in ADM, an additional claim form will generated.
- These modifiers should only be coded once. If TPOCS reads the same modifier on the same CPT-4, it will be considered a duplicate and will not be billed.

• DME/DMS is equipment or supplies that can withstand repeated use
  – Is primarily used to serve a medical purpose
  – Is not generally useful to a person in the absence of an illness or injury
  – Is appropriate for use in the home
  – Examples of durable medical equipment include:
    • Hospital beds
    • Wheelchairs
    • Oxygen tanks
  –Examples of durable medical supplies include:
    • Neck braces
    • Ace bandages
    • Crutch supports

• DME/DMS services will be accompanied by modifiers when applicable. The two most common modifiers are:
  – -RR for rented equipment
  – -NU for new equipment



- The use of these modifiers indicate that an anesthesiology professional performed services.
- These services will automatically trigger the system to put the anesthesia services on the CMS-1500 Claim Form.
- The provider that is listed in the second position in ADM will be listed on the claim form as the provider of services.
- Without the use of these modifiers, the system will automatically put the anesthesia services on the CMS-1500 Claim Form but will list the primary provider as the provider of service. (The anesthesiologist/CRNA will not be paid even if they were listed in the second provider position in ADM.)

  – **CRNA:** Certified Registered Nurse Anesthetist

Multiple Modifiers for a Single CPT-4/HCPCS

28285-(modifier)

Local Code	Procedure	Class Nbr	Rate	Effective Date

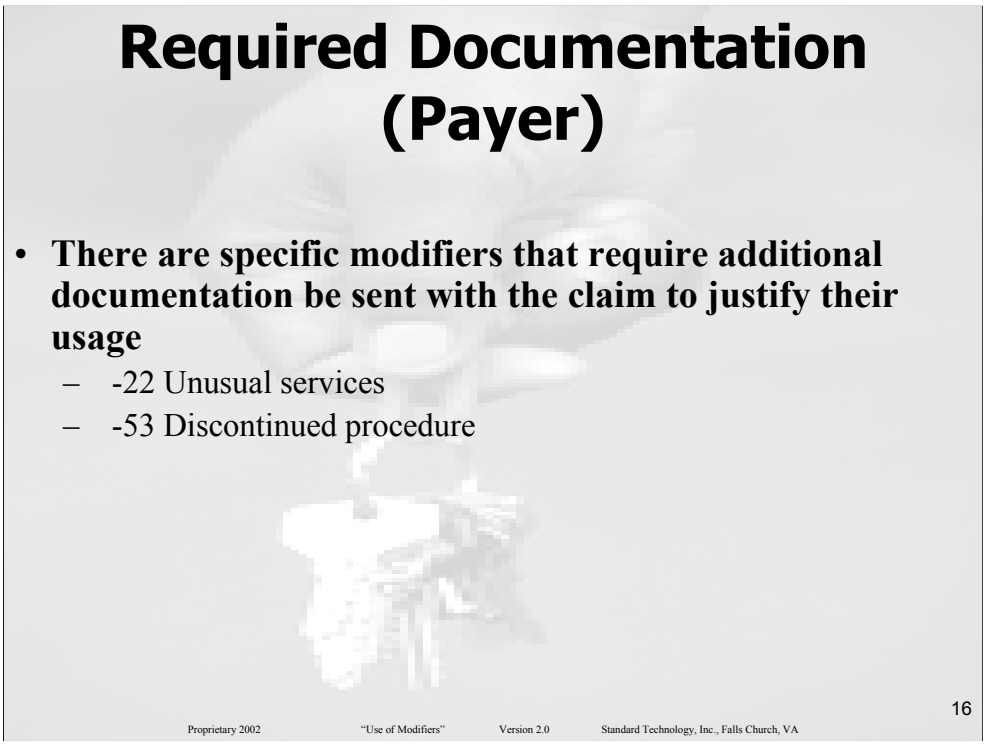
UB-92 Form: FL 42-47

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	
360	Operating Room Services - General	28285-TA	07232001	1	$ 682	91
360	Operating Room Services - General	28285-T5	07232001	1	$ 682	91
360	Operating Room Services - General	28285-T1	07232001	1	$ 682	91
001	Totals			3	$ 2048	43

15

Proprietary 2002 "Use of Modifiers" Version 2.0 Standard Technology, Inc., Falls Church, VA

- The same CPT-4/HCPCS code may be coded more than once if different modifiers are used.
- For example, a patient presented to the clinic with chief complaint of pain in both feet. Patient was diagnosed with hammertoes in the great toe of both the right and left foot; in addition, the left foot, second digit. Correction of the hammertoes was performed.
- The procedure was coded with 28285 and to represent the different body sites, the following modifiers were used:
  - -TA Left Foot, Great Toe
  - -T5 Right Foot, Great Toe
  - -T1 Left Foot, Second Digit
- The modifiers indicate that the procedures were not duplicate; therefore, the rates are filled in on the claim form.



- Billers will need to be familiar with those modifiers requiring documentation to be submitted with the claim.
- Documentation must be specific, not general.
- Payers may increase reimbursement with this justification.

- **-22 Unusual Circumstances:**
  - Due to circumstances, the procedure was lengthy, unusual and/or work was increased by approximately 25-50% of what would normally be required.

- **-53 Discontinued Procedure:**
  - When the well-being of a patient is threatened, the physician may elect to terminate a surgical or diagnostic procedure.
  - The procedure was started but not finished.
  - This modifier informs the payer about the procedure termination and allows for reimbursement up to the point when service was terminated.
  - This modifier does not indicate cancellation of services prior to the start of a procedure.

Required Documentation (Medical Record)

- **These modifiers require additional documentation in the medical record only**
  - -25 significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
  - -27 multiple outpatient hospital evaluation and management encounters on the same date

17

Proprietary 2002 "Use of Modifiers" Version 2.0 Standard Technology, Inc., Falls Church, VA

- Both modifiers are for informational purposes.
- They do affect the reimbursement because with their usage, payers may not reject multiple E/M codes reported for the same date of service.

- Both modifiers are used for code ranges 92002-92014, 99201-99499 and G0101-G0175:

  - **-25** as an example, the patient went in for a physical and also had respiratory complaints
    - The physician noted some abnormalities in the breathing and evaluated the problem.
    - In this situation, the same physician would need to perform another exam beyond the physical and code an additional E/M.

  - **-27** this modifier is used to indicate that the patient went to separate and distinct visits within the same day (e.g., present to ER and sent to OB)
    - This means that the patient was examined by more than one physician.

Key Points

- **Biller may see duplicate CPT-4 codes listed on a claim form: each code must have a different modifier or may be considered duplicate charges**
- **Multiple Modifiers will be available per CPT.**
- **Multiple E&M Codes will be available in future releases.**
- **Units of service can now be accounted for.**
- **Some modifiers substantiate care only and some effect reimbursement.**


19
Proprietary 2002 "Use of Modifiers" Version 1.0 Standard Technology, Inc., Falls Church, VA

Questions?

CPT-4/HCPCS Codes to Modifiers Mapping

Code Set	Modifiers	Descriptor	Rate Calculation
E/M 99201-99499	-21	Prolonged evaluation and management services	Global rate
	-24	Unrelated evaluation and management service by the same physician during a postoperative period.	Global rate
	-25	Significant separately identifiable e/m services by the same physician on the same day of a procedure or other service	Global rate
	-27	Multiple outpatient E&M encounters on the same date	Global rate
	-32	Mandated services	Global rate
	-52	Reduced services	Global rate – it will be up to the payer to decide how much to reduce the payment.
	-57	Decision for surgery	Global rate
	-CC	Procedure code change	
Anesthesia 00100-01999	-22	Unusual services	Flat rate
	-23	Unusual anesthesia	Flat rate
	-32	Mandated services	Flat rate
	-47	Anesthesia by surgeon	Flat rate
	-51	Multiple procedures	Global rate
	-53	Discontinued procedure	Flat rate
	-59	Distinct procedural service	Flat rate
	-AA	Anesthesia service performed personally by anesthesiologist	Flat rate
	-AD	Medical supervision by a physician; more than four concurrent anesthesia procedures	Flat rate
	-AS	Physician assistant, nurse practitioner or clinical nurse specialist services for assistant-at-surgeon	Flat rate
	-CC	Procedure code change	
	-G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure	This modifier will not be used until the system is capable of calculating anesthesia by minutes of service.
	-G9	MAC for patient who has history of severe cardio-pulmonary condition	This modifier will not be used until the system is capable of calculating anesthesia by minutes of service.
	-P1	Normal healthy patient	This modifier will not be used until the system is capable of calculating anesthesia by minutes of service.
	-P2	Patient with mild systemic disease	This modifier will not be used until the system is capable of calculating anesthesia by minutes of service.

CPT-4/HCPCS Codes to Modifiers Mapping

Code Set	Modifiers	Descriptor	Rate Calculation
	-P3	Patient with severe systemic disease	This modifier will not be used until the system is capable of calculating anesthesia by minutes of service.
	-P4	Patient with severe systemic disease that is a constant threat to life	This modifier will not be used until the system is capable of calculating anesthesia by minutes of service.
	-P5	Moribund patient who is not expected to survive without the operation	This modifier will not be used until the system is capable of calculating anesthesia by minutes of service.
	-P6	Declared brain-dead patient whose organs are being removed for donor purposes	This modifier will not be used until the system is capable of calculating anesthesia by minutes of service.
	-QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals	Flat rate
	-QS	Monitored anesthesia care	This modifier will not be used until the system is capable of calculating anesthesia by minutes of service.
	-QX	CRNA service with medical direction by a physician	Flat rate
	-QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	Flat rate
	-QZ	CRNA service without medical direction by a physician	Flat rate
Surgery 10040-69990	-22	Unusual services	Global rate
	-26	Professional component	Rate is derived from the Professional Rate column of the Component Table
	-32	Mandated services	Global rate
	-47	Anesthesia by surgeon	Global rate
	-50	Bilateral procedure	Rate that is displayed on the form is 2x the CMAC rate. Units of service field is filled with "1".
	-51	Multiple procedures	Global rate

CPT-4/HCPCS Codes to Modifiers Mapping

Code Set	Modifiers	Descriptor	Rate Calculation
	-52	Reduced services	Global rate – it will be up to the payer to decide how much to reduce the payment.
	-53	Discontinued procedure	This modifier will not be used at this time until system changes are made.
	-54	Surgical care only	Global rate
	-55	Postoperative care only	Global rate
	-56	Preoperative care only	Global rate
	-58	Staged or related procedure or service by the same physician during the postoperative period	Global rate
	-59	Distinct procedural service	Global rate
	-62	Two surgeons	Global rate
	-66	Surgical team	Global rate
	-76	Repeat procedure by the same physician	Global rate
	-77	Repeat procedure by another physician	Global rate
	-78	Return to the operating room for a related procedure during the postoperative period	Global rate
	-79	Unrelated procedure or service by the same physician during the postoperative period	Global rate
	-80	Assistant surgeon	Global rate
	-81	Minimum assistant surgeon	Global rate
	-82	Assistant surgeon (when qualified resident surgeon not available)	Global rate
	-90	Reference (outside) laboratory	Global rate
	-99	Multiple modifiers	Global rate
	-LT	Left side	Global rate
	-RT	Right side	Global rate
	-E1	Upper left, eyelid	Global rate
	-E2	Lower left, eyelid	Global rate
	-E3	Upper right, eyelid	Global rate
	-E4	Lower right, eyelid	Global rate
	-FA	Left hand, thumb	Global rate
	-F1	Left hand, second digit	Global rate
	-F2	Left hand, third digit	Global rate
	-F3	Left hand, fourth digit	Global rate
	-F4	Left hand, fifth digit	Global rate
	-F5	Right hand, thumb	Global rate
	-F6	Right hand, second digit	Global rate
	-F7	Right hand, third digit	Global rate
	-F8	Right hand, fourth digit	Global rate
	-F9	Right hand, fifth digit	Global rate
	-TA	Left foot, great toe	Global rate
	-TC	Technical component	Rate is derived from the Technical Rate column of the Component Table
	-T1	Left foot, second digit	Global rate
	-T2	Left foot, third digit	Global rate
	-T3	Left foot, fourth digit	Global rate

CPT-4/HCPCS Codes to Modifiers Mapping

Code Set	Modifiers	Descriptor	Rate Calculation
	-T4	Left foot, fifth digit	Global rate
	-T5	Right foot, great toe	Global rate
	-T6	Right foot, second digit	Global rate
	-T7	Right foot, third digit	Global rate
	-T8	Right foot, fourth digit	Global rate
	-T9	Right foot, fifth digit	Global rate
	-CC	Procedure code change	
Radiology 70010-79999	-22	Unusual procedural services	Global rate
	-26	Professional component	Rate is derived from the Professional Rate column of the Component Table
	-32	Mandated services	Global rate
	-50	Bilateral procedure	Rate that is displayed on the form is 2x the CMAC rate. Units of service field is filled with "1"
	-51	Multiple procedures	Global rate
	-52	Reduced services	Global rate – it will be up to the payer to decide how much to reduce the payment.
	-53	Discontinued procedure	This modifier will not be used until systems changes can be made.
	-58	Staged or related procedure or service by the same physician during the postoperative period	Global rate
	-59	Distinct procedural service	Global rate
	-76	Repeat procedure by the same physician	Global rate
	-77	Repeat procedure by another physician	Global rate
	-78	Return to the operating room for a related procedure during the postoperative period	Global rate
	-79	Unrelated procedure or service by the same physician during the postoperative period	Global rate
	-90	Reference (outside) laboratory	Global rate
	-99	Multiple modifiers	Global rate
	-TC (-32)	Technical component	Rate is derived from the Technical Rate column of the Component Table
Pathology and Laboratory 80048-89399	-22	Unusual procedural services	Global rate
	-26	Professional component	Rate is derived from the Professional Rate column of the Component Table
	-32	Mandated services	Global rate
	-50	Bilateral procedure	Rate that is displayed on the form is 2x the CMAC rate. Units of service field is filled with "1".
	-51	Multiple procedures	Global rate

CPT-4/HCPCS Codes to Modifiers Mapping

Code Set	Modifiers	Descriptor	Rate Calculation
	-52	Reduced services	Global rate – it will be up to the payer to decide how much to reduce the payment.
	-53	Discontinued procedure	This modifier will not be used until systems changes can be made.
	-59	Distinct procedural service	Global rate
	-90	Reference (outside) laboratory	Global rate
	-91	Repeat clinical diagnostic laboratory test	Global rate
	-TC (-32)	Technical component	Rate is derived from the Technical Rate column of the Component Table
	-CC	Procedure code change	
Medicine 90281-99199	-22	Unusual procedural services	Global rate
	-26	Professional component	Rate is derived from the Professional Rate column of the Component Table
	-32	Mandated services	Global rate
	-50	Bilateral procedure	Rate that is displayed on the form is 2x the CMAC rate. Units of service field is filled with "1".
	-51	Multiple procedures	Global rate
	-52	Reduced services	Global rate – it will be up to the payer to decide how much to reduce the payment.
	-53	Discontinued procedure	Global rate
	-55	Postoperative care only	Global rate
	-56	Preoperative care only	Global rate
	-58	Staged or related procedure or service by the same physician during the postoperative period	Global rate
	-59	Distinct procedural service	Global rate
	-76	Repeat procedure by the same physician	Global rate
	-77	Repeat procedure by another physician	Global rate
	-78	Return to the operating room for a related procedure during the postoperative period	Global rate
	-79	Unrelated procedure or service by the same physician during the postoperative period	Global rate
	-90	Reference (outside) laboratory	Global rate
	-LT	Left side	Global rate
	-RT	Right side	Global rate
	-E1	Upper left, eyelid	Global rate
	-E2	Lower left, eyelid	Global rate
	-E3	Upper right, eyelid	Global rate
	-E4	Lower right, eyelid	Global rate
	-FA	Left hand, thumb	Global rate
	-F1	Left hand, second digit	Global rate
	-F2	Left hand, third digit	Global rate

CPT-4/HCPCS Codes to Modifiers Mapping

Code Set	Modifiers	Descriptor	Rate Calculation
	-F3	Left hand, fourth digit	Global rate
	-F4	Left hand, fifth digit	Global rate
	-F5	Right hand, thumb	Global rate
	-F6	Right hand, second digit	Global rate
	-F7	Right hand, third digit	Global rate
	-F8	Right hand, fourth digit	Global rate
	-F9	Right hand, fifth digit	Global rate
	-TA	Left foot, great toe	Global rate
	-T1	Left foot, second digit	Global rate
	-T2	Left foot, third digit	Global rate
	-T3	Left foot, fourth digit	Global rate
	-T4	Left foot, fifth digit	Global rate
	-T5	Right foot, great toe	Global rate
	-T6	Right foot, second digit	Global rate
	-T7	Right foot, third digit	Global rate
	-T8	Right foot, fourth digit	Global rate
	-T9	Right foot, fifth digit	Global rate
	-LC	Left circumflex, coronary artery	Global rate
	-LD	Left anterior descending coronary artery	Global rate
	-RC	Right circumflex, coronary artery	Global rate
	-RD	Right anterior descending coronary artery	Global rate
	-CC	Procedure code change	
Ambulance (A0999)	-QM	Ambulance service by arrangement	Flat rate
	-QN	Ambulance service provided directly	Flat rate
DME/DMS (A4214-A7509)	-NU	DME purchase	
	-RR	DME rental	
	-UE	Used Durable Medical Equipment	
	-CC	Procedure code change	
DME/DMS (E0100-E1900)	-NU	DME purchase	
	-RR	DME rental	
	-UE	Used Durable Medical Equipment	
	-CC	Procedure code change	
DME/DMS (L0100-L9900)	-NU	DME purchase	
	-RR	DME rental	
	-UE	Used Durable Medical Equipment	
	-CC	Procedure code change	
DME/DMS (G001-G0201)	-NU	DME purchase	
	-RR	DME rental	
	-UE	Used Durable Medical Equipment	
	-CC	Procedure code change	
DME/DMS (P2038-P9615)	-NU	DME purchase	
	-RR	DME rental	
	-UE	Used Durable Medical Equipment	
	-CC	Procedure code change	
DME/DMS (Q-0091-Q0115)	-NU	DME purchase	
	-RR	DME rental	
	-UE	Used Durable Medical Equipment	
	-CC	Procedure code change	

CPT-4/HCPCS Codes to Modifiers Mapping

Code Set	Modifiers	Descriptor	Rate Calculation
DME/DMS (W0002-W0019)	-NU	DME purchase	
	-RR	DME rental	
	-UE	Used Durable Medical Equipment	
	-CC	Procedure code change	
Immunization (J0120-J9999, 90476-90799)	-22	Unusual procedural services	Global rate
	-26	Professional component	Rate is derived from the Professional Rate column of the Component Table
	-32	Mandated services	Global rate
	-50	Bilateral procedure	Rate that is displayed on the form is 2x the CMAC rate. Units of service field is filled with "1".
	-51	Multiple procedures	Global rate
	-52	Reduced services	Global rate – it will be up to the payer to decide how much to reduce the payment.
	-53	Discontinued procedure	Global rate
	-55	Postoperative care only	Global rate
	-56	Preoperative care only	Global rate
	-58	Staged or related procedure or service by the same physician during the postoperative period	Global rate
	-59	Distinct procedural service	Global rate
	-76	Repeat procedure by the same physician	Global rate
	-77	Repeat procedure by another physician	Global rate
	-78	Return to the operating room for a related procedure during the postoperative period	Global rate
	-79	Unrelated procedure or service by the same physician during the postoperative period	Global rate
	-90	Reference (outside) laboratory	Global rate
	-LT	Left side	Global rate
	-RT	Right side	Global rate
	-E1	Upper left, eyelid	Global rate
	-E2	Lower left, eyelid	Global rate
	-E3	Upper right, eyelid	Global rate
	-E4	Lower right, eyelid	Global rate
	-FA	Left hand, thumb	Global rate
	-F1	Left hand, second digit	Global rate
	-F2	Left hand, third digit	Global rate
	-F3	Left hand, fourth digit	Global rate
	-F4	Left hand, fifth digit	Global rate
	-F5	Right hand, thumb	Global rate
	-F6	Right hand, second digit	Global rate
	-F7	Right hand, third digit	Global rate
	-F8	Right hand, fourth digit	Global rate
	-F9	Right hand, fifth digit	Global rate
	-TA	Left foot, great toe	Global rate
	-T1	Left foot, second digit	Global rate

CPT-4/HCPCS Codes to Modifiers Mapping

Code Set	Modifiers	Descriptor	Rate Calculation
	-T2	Left foot, third digit	Global rate
	-T3	Left foot, fourth digit	Global rate
	-T4	Left foot, fifth digit	Global rate
	-T5	Right foot, great toe	Global rate
	-T6	Right foot, second digit	Global rate
	-T7	Right foot, third digit	Global rate
	-T8	Right foot, fourth digit	Global rate
	-T9	Right foot, fifth digit	Global rate
	-LC	Left circumflex, coronary artery	Global rate
	-LD	Left anterior descending coronary artery	Global rate
	-RC	Right circumflex, coronary artery	Global rate
	-CC	Procedure code change	

- Welcome, this presentation deals with the **CMS-1500** Claim Form.
- Does anyone know what the **HCFA-1500** claim form is or has anyone used this form in the past?
  - The CMS-1500 is the same form; however, the only difference is its name change. The name will be physically changed on the form in the future
  - CMS stands for Centers for Medicare and Medicaid Services and HCFA changed to this name in June 2001

Note to Trainer: Have the class refer to the CMS-1500 Claim Form example and instructions attached at the end of this presentation.

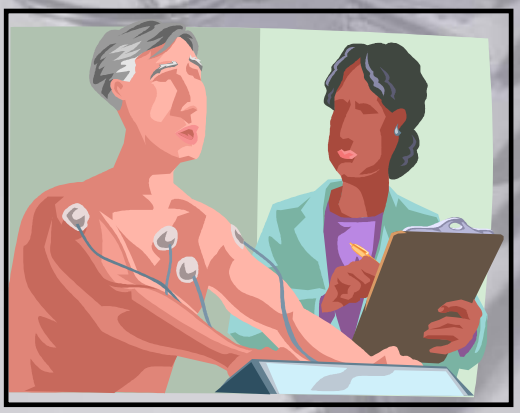
Objectives

- **Describe the functionality and purpose of using the CMS-1500**
- **Review the items that impact Outpatient Itemized Billing**

- **Professional Services:**
  - Services that have a "professional" component in which the physician "reads" and interprets the result of a test performed by a technician
  - The service will be designated by a CPT-4 code and modifier – 26 on the CMS-1500 Claim Form
  - The technical component will be recorded on the UB-92 Claim Form with the modifier –TC
- **Evaluation & Management (E & M) Codes:**
  - These codes will be itemized first, if applicable
- **Modifiers:**
  - Are two-digit adjectives
  - Give additional information that is not part of the CPT-4/HCPCS code description
  - Can be numeric, alpha-numeric, or alpha (e.g. - 26 Professional Component)

CMS-1500 Claim Form Sections

- **Items 1-13:**
  Patient and Insured Information



MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) / (Medicaid #) / (Sponsor's SSN) / (VA File #) / X (SSN or ID) / (SSN) / (ID)	123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane M.	3. PATIENT'S BIRTHDATE / SEX: M / F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Jane M.	
5. PATIENT'S ADDRESS (No., Street): 123 Patients Street	6. PATIENT RELATIONSHIP TO INSURED: Self X / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street): 123 Patients Street	
CITY: Anywhere / STATE: US	8. PATIENT STATUS: Single / Married X / Other
CITY: Anywhere / STATE: US	
ZIP CODE: 00000 / TELEPHONE (Include Area Code): (888) 123-4567	Employed / Full-Time Student X / Part-Time Student
ZIP CODE: 00000 / TELEPHONE (Include Area Code): (888) 123-4567	
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 123456	
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES / NO X
a. INSURED'S DATE OF BIRTH / SEX: MM DD YYYY: 9 20 1965 / M / F X	
OTHER INSURED'S DATE OF BIRTH / SEX: M / F	b. AUTO ACCIDENT? / PLACE (State): YES / NO X
b. EMPLOYER'S NAME OR SCHOOL NAME: XYZ Public Schools	
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME: Royal Pacific Ins. Co.	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO X (If yes, return to and complete item 9 a-d.)	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Signature on file	09/01/2000
SIGNED	DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signature on file	
SIGNED	

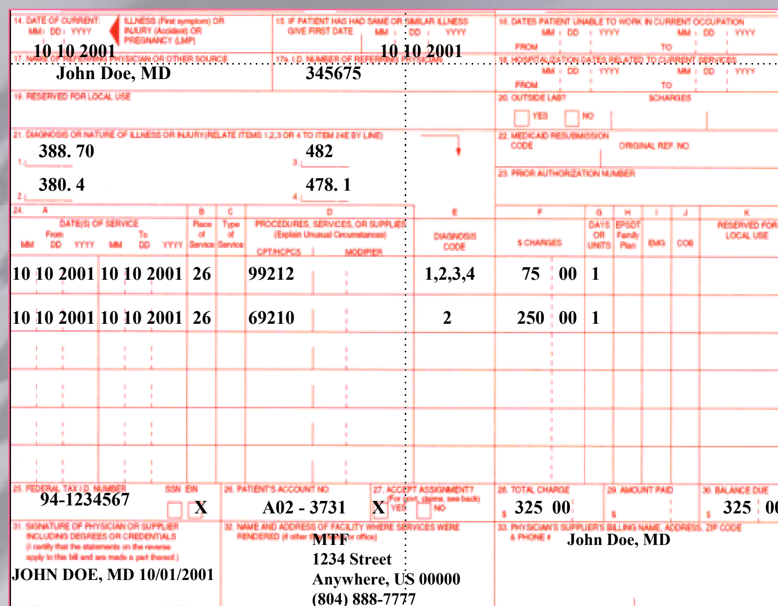
3

"CMS-1500" Version 2.0 Standard Technology, Inc., Falls Church, VA

- The CMS-1500 Claim Form has **33 items** and is divided into two different sections:
  - **Items 1-13**: The first half of the claim form represents the patient and insured information

CMS-1500 Claim Form Sections

- **Items 14-33:**
  Physician or Supplier Information



- **Items 14-33:** The second half of the Claim Form represents the physician/supplier information

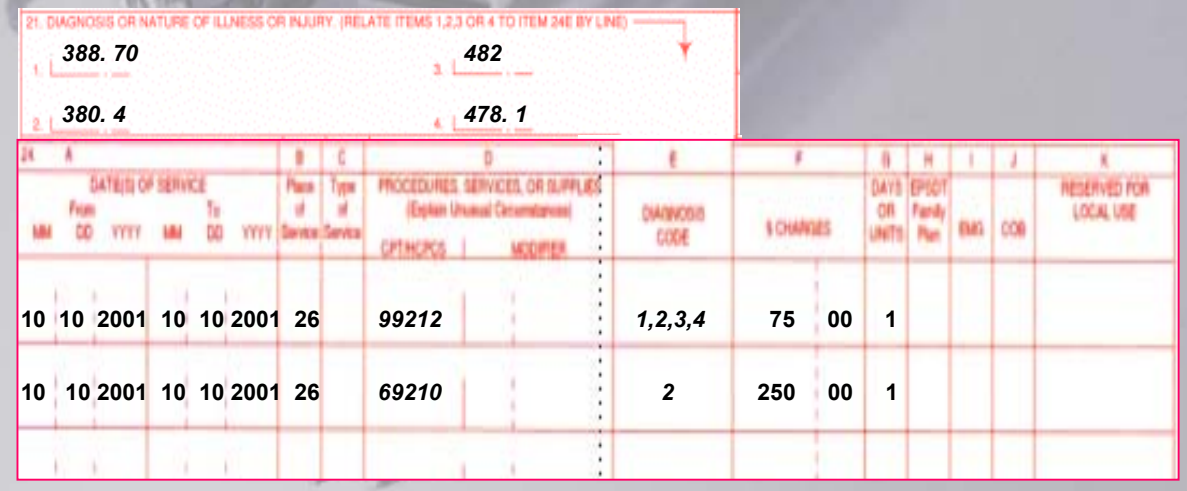
Required CMS-1500 Claim Form Items

- Item 21
- Item 24A
- Item 24B
- Item 24D
- Item 24E
- Item 24F
- Item 24G
- Item 25
- Item 26
- Item 28
- Item 30
- Item 31
- Item 32
- Item 33

- The items on this slide are very essential for Outpatient Itemized Billing
  - Please refer to the CMS-1500 Instruction Sheet for more detailed information regarding claim form items
- We will discuss each item listed on the slide in more detail on the following slides

Diagnosis

- **Item 21: Diagnosis or Nature of Illness or Injury**
- **Item 24E: Diagnosis Code**



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 388. 70 3. 482

2. 380. 4 4. 478. 1

24 A DATE(S) OF SERVICE From MM	DD	YYYY	To MM	DD	YYYY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES		G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
10	10	2001	10	10	2001	26		99212		1,2,3,4	75	00	1				
10	10	2001	10	10	2001	26		69210		2	250	00	1				

• **Item 21:** The ICD-9-CM code for the patient's diagnosis/condition
  – The ICD-9-CM code must be coded to the highest specificity and ranked in order of priority

• **Item 24E:** The pointer number (1-4) from Item 21 that is applicable to that specific procedure, service or supply should appear

– **In the example on the slide:**

- **In line 1**, the diagnosis pointers indicate that the procedure (99212) performed are related to all of the diagnosis codes
- **In line 2**, the diagnosis pointer indicates that the procedure (69210) performed is related to the secondary diagnosis, 380.4 (impacted cerumen)

Note: There is a maximum of **six itemized lines of charges** that can be populated on the CMS-1500. Any additional itemized lines will be continued on new CMS-1500 Claim Forms.

Procedures and Associated Charges

- **Item 24A: Dates of Service**
- **Item 24B: Place of Service**
- **Item 24D: Procedures, Services or Supplies**
- **Item 24F: Charges**
- **Item 24G: Days or Units**

24 A DATE(S) OF SERVICE From MM	DD	YYYY	To MM	DD	YYYY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
10	10	2001	10	10	2001	26		99212		1	35 00	1				
10	10	2001	10	10	2001	26		70010	26	1	100 00	1				

- **Item 24A:** The eight-digit date (MMDDCCYY) of the time period in which the services were performed

- **Item 24B:** The code **"26"** which represents an MTF. This code should automatically print on all CMS-1500s. (TPOCS default) If a code other than "26" appears, a prompt will ask if this is the appropriate place of service code.

- **Item 24D:** The CPT-4/HCPCS code(s) for the procedures, services or supplies furnished to the patient will be populated here.
  - **Modifiers** should be coded by the coder/provider, if required

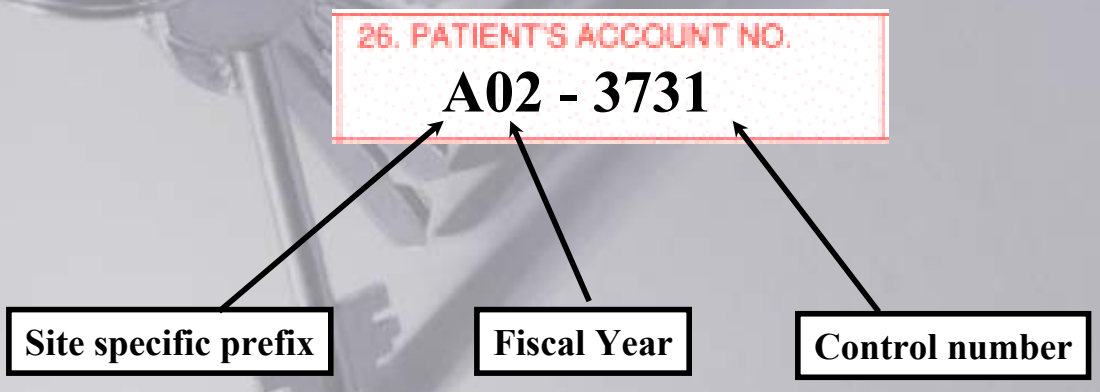
- **Item 24F:** The system will automatically produce the charge based on each listed service.

- **Item 24G:** The number of days or units that were supplied for that particular CPT/HCPCS code listed in that line will be populated here.
  - If only one service was provided, the number "1" should appear

Note: This particular section depicts the major change with outpatient itemized billing as opposed to all inclusive billing. Each procedure/service, date of service and charge is indicated on its specific detail line for itemized billing.

Patient's Account Number

- **Item 26: Patient's Account Number**

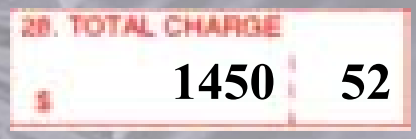


8

- The current method in how the Patient's Account Number is created has not changed.
- The Patient's Account Number is assigned by the MTFs accounting system to identify the patient.
- There will be a Site specific prefix (based on DMIS ID) followed by a sequence number.
- All additional claims will be numbered in succession.

Total Charges

- **Item 28: Total Charge**



- **Item 30: Balance Due**

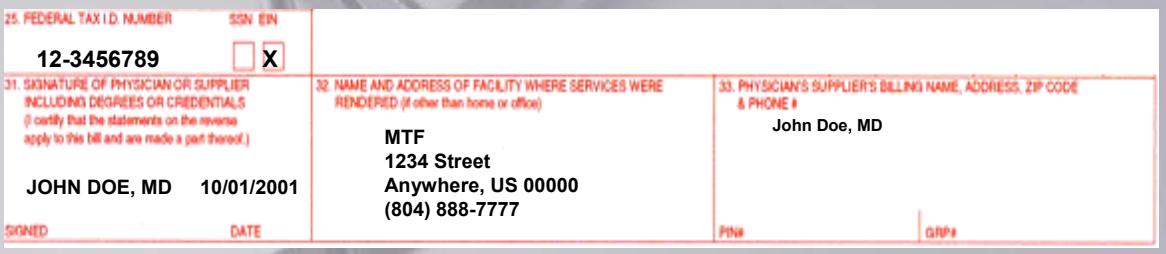
9

"CMS-1500" Version 2.0 Standard Technology, Inc., Falls Church, VA

- **Item 28:** The system will automatically produce the **Total Charge** based on the procedure code(s).
- **Item 30:** The system will automatically produce the **Balance Due** based on the procedure code(s).
  - This should match **Item 28**
    - **In the cases where TPOCS is sending out a secondary** bill (i.e., primary insurance paid and the secondary insurance is billed the remainder), the amount paid field should be automatically filled in by the system
      - That amount will be deducted from the total
      - The line items will reflect the correct charges from the corresponding rate tables but the insurer can tell what was paid by the primary insurer

Physician Information

- **Item 25: Federal Tax ID Number**
- **Item 31: Signature of Physician or Supplier**
- **Item 32: Name and Address of Facility Where Services Were Rendered**
- **Item 33: Physician, Supplier Billing Name, Address, Zip Code and Phone**



- **Item 25:** The Federal Tax ID number for the facility

- **Item 31:** The signature or stamp of the provider of service or supplier or his/her representative and the date the form was signed should be completed. This area can also be used to indicate the TPC Manager and that the bill has been reviewed.

- **Item 32:** The name, address and telephone number of the MTF

- **Item 33:** The name, address and phone number of the physician who rendered the services.

  – **Pin#: (Currently, DoD does not use the PIN #)**
  – **Group#: (Currently, DoD does not use the Group #)**

Items that are Not Required for Outpatient Itemized Billing

- Item 10D
- Item 16
- Item 18
- Item 19
- Item 20
- Item 22
- Item 23
- Item 24H
- Item 24I
- Item 24J
- Item 24K
- Item 29

• The items on this slide are not required for to Outpatient Itemized Billing.

For training purposes, the items that are not required for outpatient itemized billing are indicated with an **"X"**

Key Points

- **Evaluation and Management code (one per provider per CMS-1500 with applicable procedure codes when indicated; up to six itemized lines for each CMS-1500)**
- **Physician or representative signature/stamp required (cannot accept "computer generated" as signature)**
- **Anesthesia services and reflective CPT-4 codes will be placed on CMS-1500**

- Are there any questions?

CMS-1500 Claim Form Example

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [X] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane M.

3. PATIENT'S BIRTHDATE MM DD YYYY: SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Jane M.

5. PATIENT'S ADDRESS (No., Street): 123 Patients Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Patients Street

CITY: Anywhere STATE: US

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: Anywhere STATE: US

ZIP CODE: 00000 TELEPHONE (include Area Code): (888) 123-4567

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 00000 TELEPHONE (include Area Code): (888) 123-4567

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 123456

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YYYY: 9 20 1965 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YYYY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: XYZ Public Schools

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Royal Pacific Ins. Co.

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature on file

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Signature on file

14. DATE OF CURRENT: MM DD YYYY: 10 10 2001 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

09/01/2000

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YYYY: 10 10 2001

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YYYY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: John Doe, MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 345675

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YYYY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 388. 70
2. 380. 4
3. 482
4. 478. 1

22. MEDICAID RESUBMISSION CODE ORIG. REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YYYY	To MM DD YYYY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
10 10 2001	10 10 2001	26		99212		1,2,3,4	75 00	1				
10 10 2001	10 10 2001	26		69210		2	250 00	1				

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 94-1234567

26. PATIENT'S ACCOUNT NO.: A01 - HC3731

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 325 00

29. AMOUNT PAID

30. BALANCE DUE: $ 325 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

JOHN DOE, MD 10/01/2001

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

MTF
1234 Street
Anywhere, US 00000
(804) 888-7777

33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

John Doe, MD

PIN# GRP#

CMS-1500 Claim Form Instructions

Item 1: Insured's I.D. Number, **Required**

DoD Format Requirements: Required
Enter the insured's social security number

Item 2: Patient's Name (Last Name, First Name, Middle Initial), **Required**

DoD Format Requirements: Required
Enter the insured's last name, first name, and middle initial

Item 3: Patient Birthdate, **Required**

DoD Format Requirements: Required
Enter the 8-digit birth date (MM | DD | CCYY) of the patient.

Item 4: Insured's Name (Last Name, First Name, Middle Initial), **Required**

DoD Format Requirements: Required
Enter the insured's last name, first name, and middle initial

Item 5: Patient's Address, **Required**

DoD Format Requirements: Required
Enter the mailing address and telephone number of the patient in the corresponding boxes.

Item 6: Patient Relationship to Insured, **Required**

DoD Format Requirements: Required
Check the appropriate box for the relationship of the patient listed in Item 2 to insured listed in Item 4.

Item 7: Insured's Address, **Required**

DoD Format Requirements: Required
Enter the mailing address and telephone number of the insured in the corresponding box.

Item 8: Patient Status, **Required**

DoD Format Requirements: Required
Check the appropriate box for the marital status and whether the patient is a full or part time student.

CMS-1500 Claim Form Instructions

Item 9: Other Insured's Name, Required, if applicable

DoD Format Requirements: Required, if applicable
If the yes box is checked in Item 11D, then this section (Items 9 – 9D) must be filled out.
Enter the name of the insured person (last, first, middle initial).

Item 9A: Other Insured's Policy or Group Number, Required, if applicable

DoD Format Requirements: Required, if applicable
Enter the other insured's insurance policy or group number.

Item 9B: Other Insured's Date of Birth / Sex, Required, if applicable

DoD Format Requirements: Required, if applicable
Enter the 8-digit date of birth (MM | DD | CCYY). Check the appropriate box indicating the sex of this person.

Item 9C: Employer's Name or School Name, Required, if applicable

DoD Format Requirements: Required, if applicable
Enter the employer's name or school name of the other insured person.

Item 9D: Insurance Plan Name or Program Name, Required, if applicable

DoD Format Requirements: Required, if applicable
Enter the name of the insurance plan or program related to the other insured person.

Item 10: Is Patient's Condition Related To: (Auto Accident/Other Accident), Required, if applicable

DoD Format Requirements: Required, if applicable
Check the appropriate box if the patient's condition is related to any of the following: employment (MAC), auto accident, or other accident.

Item 10d: Reserved For Local Use, Not Required

DoD Format Requirements: Not Required
Leave blank.

Item 11: Insured's Policy Group or FECA Number, Conditional

DoD Format Requirements: Required
Enter the insured's policy group or FECA number.

CMS-1500 Claim Form Instructions

Item 11A: Insured's Date of Birth / Sex, **Required**

DoD Format Requirements: Required
Enter the 8-digit date of birth (MM | DD | CCYY). Check the appropriate box indicating the sex of the insured.

Item 11B: Employer's Name or School Name, Conditional

*DoD Format Requirements:*Conditional
Enter the employer's name or school name of the insured.

Item 11C: Insurance Plan Name or Program Name, Conditional

DoD Format Requirements: Required
Enter the name of the insurance plan or program of the insured.

Item 11D: Is There Another Health Plan Benefit? Required, if applicable

DoD Format Requirements: If 'Y' is checked, Items 9-9D must be completed
Check the appropriate box to indicate whether or not there is another health insurance benefit. If yes is checked, then Items 9 – 9D must be completed.

Item 12: Patient's or Authorized Persons Signature, **Required** ("Signature on file" is acceptable.)

DoD Format Requirements: Required with a default
This item is hot keyed in with the following "Assignment of Benefits is assumed under Title 10 USC 1095" and with "Signature on file".

Item 13: Insured's Authorized Person's Signature, **Required** ("Signature on file" is acceptable.)

DoD Format Requirements: Required with a default
This item is hot keyed in with the following "Assignment of Benefits is assumed under Title 10 USC 1095" and with "Signature on file".

Item 14: Date of current Illness, Injury, or Pregnancy, Required, if applicable

DoD Format Requirements: Required, if applicable
Enter the current date of illness, injury or pregnancy (MM | DD | CCYY).

Item 15: If Patient Has Had Same or Similar Illness, Required, if applicable

DoD Format Requirements: Required, if applicable

Enter the past occurrence date (MM | DD | CCYY) of illness or injury if it is the same or similar illness or injury.

Item 16: Dates Patient Unable to Work in Current Occupation, Not Required

DoD Format Requirements: Not required
Leave blank.

Item 17: Name of Referring Physician or Other Source, Conditional

DoD Format Requirements: Conditional
Enter the Name of the Physician who referred or ordered the service.

Item 17a: ID Number of Referring Physician, Conditional

DoD Format Requirements: Conditional
Enter the number of the group ID number assigned to the physician practice/MTF by the specific third-party payer being billed. This number must match the number that is also coded in Item 33 under Grp#. The facility ID will be entered.

Item 18: Hospitalization Date Related to Current Services, Required, if applicable

DoD Format Requirements: Required, if applicable
Enter the 8-digit date (MM | DD | CCYY) if the services were provided subsequent to a related hospitalization.

Item 19: Reserved for Local Use, Not Required

DoD Format Requirements: Not Required
Leave blank.

Item 20: Outside Lab?, Not Required

DoD Format Requirements: Not Required
Leave blank.

Item 21: Diagnosis or nature of illness or injury, **Required**

DoD Format Requirements: Required
Enter the ICD-9-CM code for the patient's diagnosis/condition. The ICD-9-CM code must be coded to the highest specificity and ranked in order of priority (i.e., primary, secondary condition).

Item 22: Medicaid Resubmission, Not Required

DoD Format Requirements: Not Required
Leave blank.

CMS-1500 Claim Form Instructions

Item 23: Prior Authorization Number, Required, if applicable

DoD Format Requirements: Required, if applicable
Enter the prior authorization number for those procedures requiring prior authorization.

Item 24A: Dates of Service, **Required**

DoD Format Requirements: Required
Enter the 8-digit date (MM | DD | CCYY) of the time period in which the services were performed.

Item 24B: Place of Service, **Required**

DoD Format Requirements: Required
Enter the code representing an MTF (26). Should automatically print on all HCFA 1500 if blank. If coded other than "26", prompt to ask if this is appropriate place of service code. (Do not hot code).

Item 24C: Type of Service, Not required

DoD Format Requirements: Not required
Leave blank.

Item 24D: Procedures, Services, or Supplies, **Required**

DoD Format Requirements: Required
Enter the CPT/HCPCS code, including modifiers when applicable, for the procedures, services, or supplies furnished to the patient.

Item 24 E: Diagnosis Code, **Required**

DoD Format Requirements: Required
Enter the Pointer number (1-4) from Item 21 that is applicable to that specific procedure, service or supply furnished.

Item 24F: Charges, **Required**

DoD Format Requirements: Required
Enter the charge for each listed service.

Item 24G: Days or Units, **Required**

DoD Format Requirements: Required, if applicable
Enter the number of days or units that were supplied for that particular CPT/HCPCS code listed in that line. If only one service was provided, the numeral 1 must be entered.

CMS-1500 Claim Form Instructions

Item 24H: EPSDT Family Plan, Not Required

DoD Format Requirements: Not Required
Leave blank.

Item 24I: EMG, Not Required

DoD Format Requirements: Not Required
Leave blank.

Item 24J: COB, Optional

DoD Format Requirements:
Leave blank.

Item 24K: Reserved for Local Use, Not Required

DoD Format Requirements: Not Required
Leave blank.

Item 25: Federal Tax I.D. Number, **Required**

DoD Format Requirements: Required
Enter the Federal Tax ID number for the physician performing the services.

Item 26: Patient' Account No., **Required**

DoD Format Requirements: Required
Enter the patient's account number that is assigned by the MTF's accounting system to identify that particular patient.

Item 27: Accept Assignment, **Required**

DoD Format Requirements:
Check the yes box to indicate that assignment of benefits is accepted pursuant to Title 10 USC 1095. TPOCS will default to "Y".

Item 28: Total Charge, **Required**

DoD Format Requirements: Required
Enter the total charges for the services provided (i.e., sum of charges in Item 24F).

CMS-1500 Claim Form Instructions

Item 29: Amount Paid, Conditional

DoD Format Requirements:
Enter $0.00 to indicate that no upfront monies were paid because the military does not collect any co-payments for services rendered.

Item 30: Balance Due, Conditional

DoD Format Requirements:
Enter the total amount of the charges. This should match Item 28.

Item 31: Signature of Physician or Supplier, **Required**

DoD Format Requirements: Required
Enter the signature of the provider of service or supplier, or his representative, and the date the form was signed. A signature or stamp is required here. Some MTFs use this area to indicate who the biller was and that the bill has been reviewed.

Item 32: Name and Address of Facility Where Service Were Rendered, **Required**

DoD Format Requirements: Required
Enter the name, address, and telephone number of the MTF.

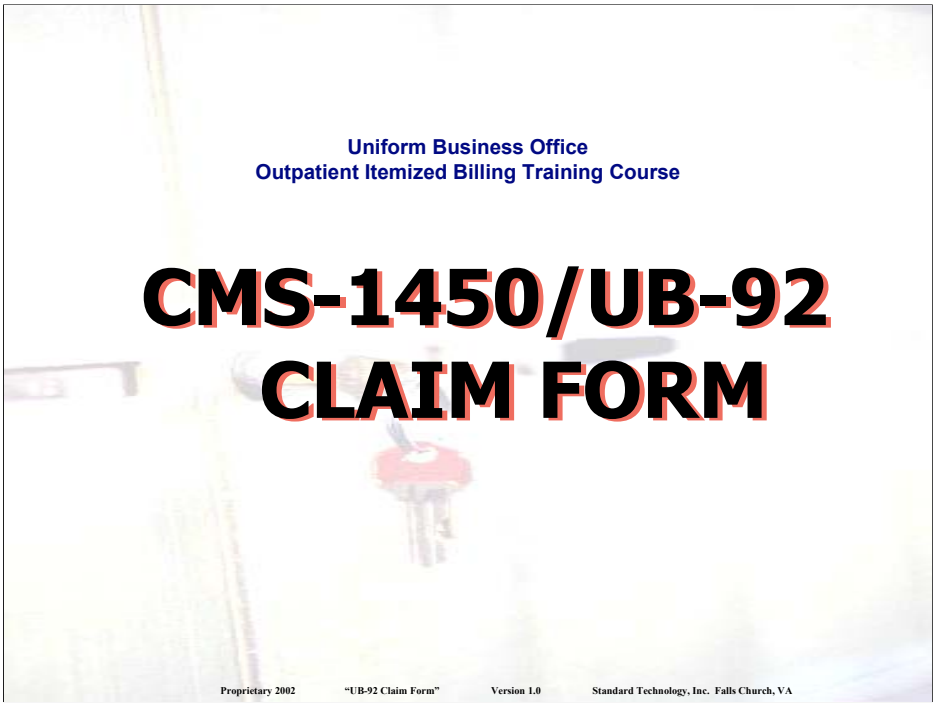
Item 33: Physician, Supplier Billing Name, Address, Zip Code & Phone, Required

Pin#:

DoD Format Requirements:
Enter the name of the physician who rendered the services. It is now required that the provider be identified with their credentials (MD, LPN, PA, RN, etc.) System should include the provider's credentials following the name. The PIN# will be filled in with the facility ID.-

Group#:

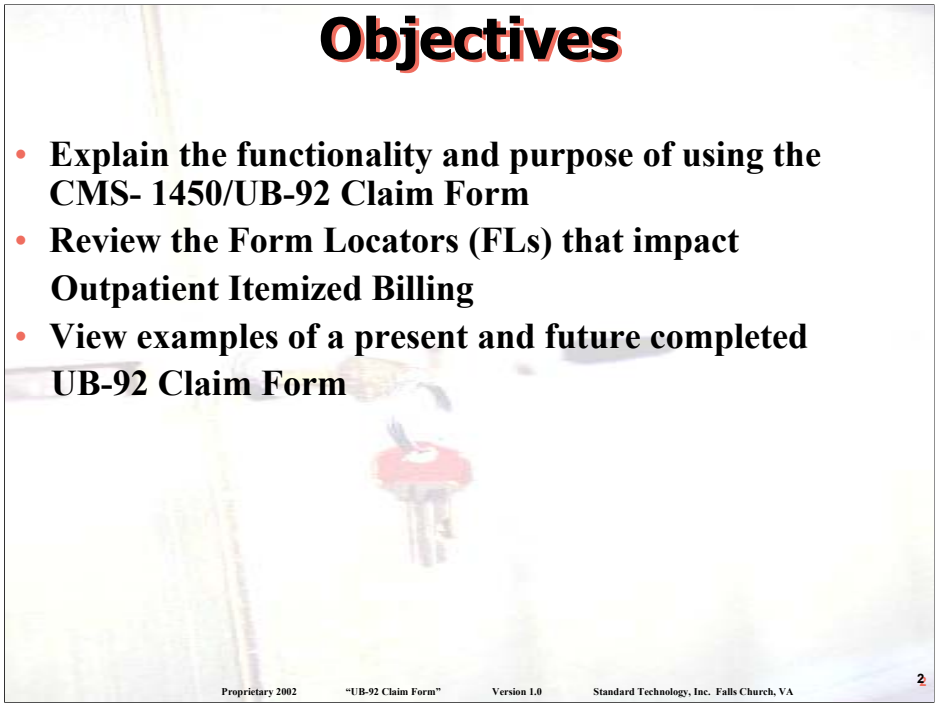
DoD Format Requirements:
Represents the group practice number for a physician/multi-specialty group. At this time DoD will not provide a group number for billing purposes.



We are going to discuss the CMS-1450, better known as the UB-92 Claim Form.

Most of you are probably familiar with the UB-92 Claim Form because it is currently the standard claim form used by MTFs' for outpatient and inpatient billing.

With Outpatient Itemized Billing the UB-92 Claim Form will be used a little differently than it is being used now.



- For Outpatient Itemized Billing the UB-92 will be used for outpatient hospital and ancillary services.

- Hospital/Ancillary Services:
  – Test and procedures ordered by healthcare providers to assist in patient diagnosis or treatment

- CPT-4 Code:
  – The service will be designated by a CPT-4 procedure code.

- Modifier:
  – A two-digit modifier will be used to indicate that the service performed deviated from the average service for that specific procedure code number or to specify a particular part of the body. (e.g., 28285-TA, Correction-Hammertoe, Left foot, Great Toe)

- Technical Component:
  – The technical component denotes services administered by medical staff such as technician and will be recorded on the UB-92 with modifier –TC. (e.g., A patient may be sent to get an x-ray. The services of the person who actually takes the x-ray would be technical services). The Professional Component is denoted with –26 modifier.

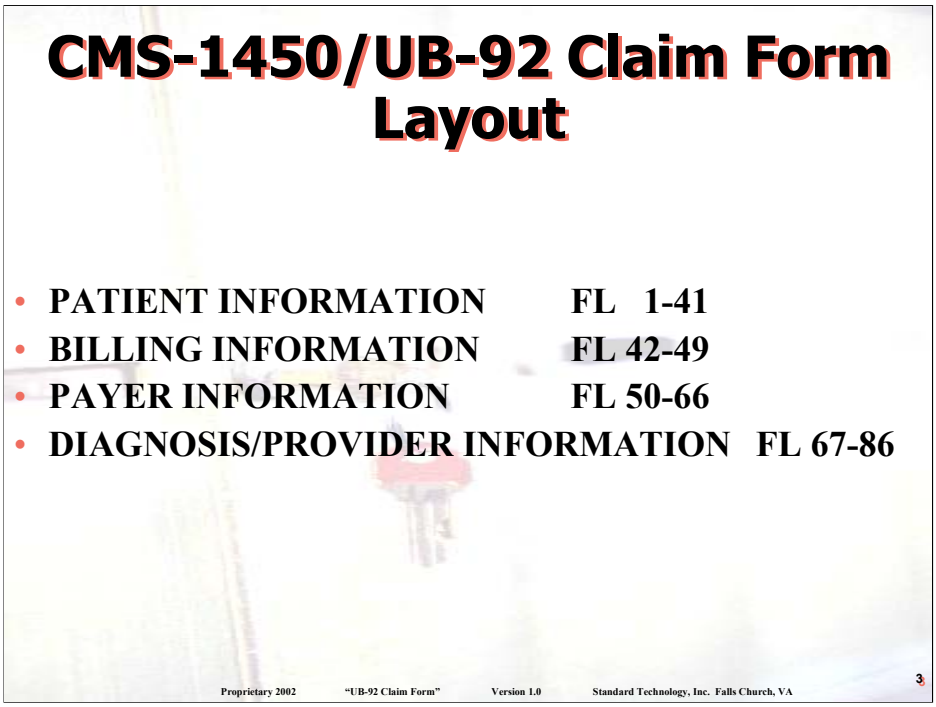
- Since most of you are familiar with the UB-92 Claim Form, we will be focusing on some of the FLs that will be new for outpatient billing or used in a different way.

- Information on required FLs that are not mentioned in this presentation can be found in your handout.

- Information on non-required FLs that are "optional" can also be found in your handout.

- You also have an example of an all-inclusive claim and an itemized claim for use as a training tool.

- **Please refer to the UB-92 claim form examples in your manual as we proceed.**

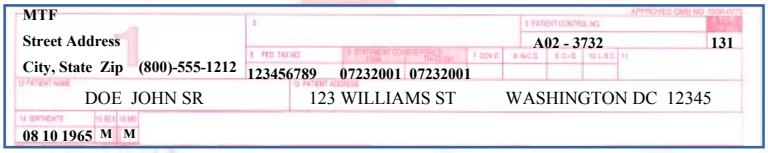


• CMS-1450/UB-92 Claim Form has 86 Form Locators and is divided into four different categories as shown.

• Does anyone know what a Form Locator is?
  – A Form Locator represents a field on the UB-92 Claim Form where valid information is placed when submitting for reimbursement from the payers.

FLs Required for Patient Information

- **FL 3** **Patient Control #**
- **FL 4** **Type of Bill**
- **FL 6** **Statement Covers Period**
- **FL 14** **Patient Birthdate**



- **FL 3 -** is the patient control #. **(Note to Trainer: Point out similarities to the CMS-1500):**
  - Comprised of Site specific prefix (based on DMIS ID) followed by a sequence number.
  - All additional claims will be numbered in succession.

- **FL 4 -** is the Type of Bill. The default type of bill will be 131 for outpatient services.
  - The Type of Bill is comprised of the following:
    - 1st Digit = **Type of facility**
    - 2nd Digit = **Type of care**
    - 3rd Digit = **Sequence** of the bill for a specific episode of care

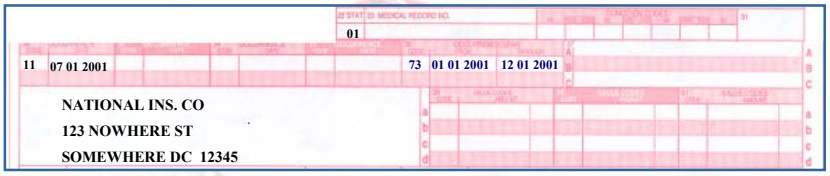
- **FL 6 -** provides the starting and ending dates of service reflected on the Claim Form (8 digit format).

- **FL 14 -** indicates the patient's birth date (8 digit format).

- **All FLs indicating dates require an 8-digit date (MMDDCCYY).**

FLs Required for Patient Information

- **FL 22 Patient Status (Conditional)**
- **FL 24-30 Condition Codes (Conditional)**
- **FL 32-35 Occurrence Codes (Conditional)**
- **FL 36 Occurrence Span & Date (Conditional)**



Proprietary 2002 "UB-92 Claim Form" Version 1.0 Standard Technology, Inc. Falls Church, VA

5

- As we review the FLs, notice on some of the slides the word **"Conditional".**
  - **Conditional means** that these FLs are required; however, the information depends on the type of situation surrounding the episode of care.
  - Remember, it is situational, for example; in a case that a patient is injured at home or at work.
  - Remember that failure to populate conditional FLs could cause problems with processing by the payer. Claims could be rejected for need of additional information.

- **FL 22 -** represents patient's disposition as of the ending date of service for the period of care provided. (e.g., Code 01 indicates routine discharge).

- **FLs 24-30 -** indicate conditions relating to the bill that may affect payer processing. (e.g., benefit eligibility period or payer codes).

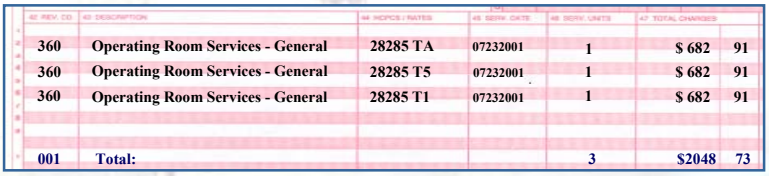
- **FLs 32-35 -** are codes and associated dates defining a significant event relating to the claim that may affect payer processing. (e.g., Code 11 indicates onset of symptoms/illness).

- **FL 36 -** indicates the related date that identifies an event that relates to the payment of the claim .

- **Now, we'll move to FLs that are in the Billing Information category.**

FLs Required for Billing Information

- **FL 42 Revenue Code**
- **FL 43 Revenue Description**
- **FL 44 HCPCS/Rates**
- **FL 45 Service Date**
- **FL 46 Service Units**
- **FL 47 Total Charges**



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	
360	Operating Room Services - General	28285 TA	07232001	1	$ 682	91
360	Operating Room Services - General	28285 T5	07232001	1	$ 682	91
360	Operating Room Services - General	28285 T1	07232001	1	$ 682	91
001	Total:			3	$2048	73

- **The FLs in this section will be used for the most significant changes in the use of the UB-92. Each revenue code, CPT-4/HCPCS, date of service and charge is indicated on its specific detail line for itemized billing.**

- **MSA and MAC claims generated on the UB-92 will be manually populated in the same manner.**

- As you can see, the information from the Multiple Modifier Scenario of the Modifier presentation, that was presented earlier, is being used as an example of what the line-item changes will look like on the UB-92 claim form when IB is implemented.

- **FL 42 -** identifies a specific accommodation and/or ancillary service performed. If this code is incorrect, it can be changed and the claim sent to the Suspense File for verification.

- **FL 43 -** describes the revenue code being used. (e.g., Operating Room Services – General (Revenue Code 360).

- **FL 44 -** indicates HCPCS/Rates being used.

  – **FYI**: **HCPCS stands for Healthcare Common Procedure Coding System**

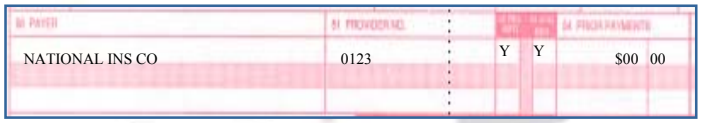
- **FL 47** – total charges. (e.g., HCPCS/CPT-4 (Rates) x Service Units = Total Charges).

- **Note:** There are a maximum of **22 itemized lines of charges that can be populated** on the UB-92 Claim Form. Line 23 will be used for the combined total of all itemized lines. Additional itemized lines (anything above 23 line items) will generate a different claim form.

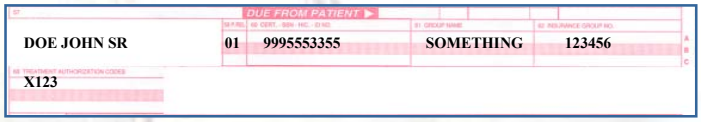
- **Next, we'll talk about FLs in the Payer Information Category.**

FLs Required for Payer Information

- **FL 54 Prior Payment (Conditional)**



- **FL 60 Certificate/SSN/Health Insurance Claim ID#**
- **FL 61 Group Name (Conditional)**
- **FL 62 Insurance Group Number (Conditional)**
- **FL 63 Treatment Authorization Codes (Conditional)**



7

- **FL 54 -** used to document any prior payments that might have been submitted.
  - (e.g., Use when billing secondary payer or resubmitting appealed claims).

- **FL 60 -** is the policy number. It can be the insured's SSN #. **It is the same information as item (1a) and item (11) on CMS-1500 Claim Form.**

- **FL 61 -** indicates the insurance company group or plan name of the policy holder.

- **FL 62 -** identifies the group policy holder identification number of the insurance company.

- **FL 63 -** indicates that services were pre-authorized by the payer. This code is assigned by the payer.

- **The last category on the UB-92 that we'll cover is the Diagnosis Information Category**

FLs Required for Diagnosis Information

- **FL 67 Principal Diagnosis Code**
- **FL 68-75 Other Diagnosis Codes (Conditional)**
- **FL 76 Admitting Diagnosis**
- **FL 77 External Causes Code (E Code)**

8

• **FL 67 -** is the ICD-9-CM principal diagnosis code.

•**FLs 68-75 -** are secondary diagnosis codes established by the provider.

• **FL 76 -** is the admitting diagnosis or "chief complaint" for the visit at the time of outpatient registration versus the principal diagnosis after care is rendered.

• **FL 77 -** is the E Code for diagnosis of injuries, poisonings, or other adverse effects. (e.g., E818 Motor Vehicle Accident involving an object thrown on the motor vehicle while in motion).

• **Note that FLs 68-75 are conditional.**

• It is possible that a Lab, Rad, or Pharmacy order may come over from CHCS without a diagnosis code. TPOCS will allow the Biller to add the Dx code for these claims.

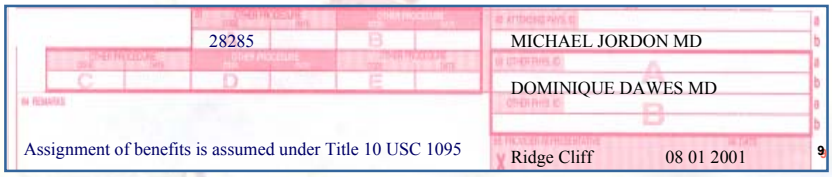
• There are two reasons why a Dx code will not come over:
  – The order is an external one and is not associated with a visit, or
  – The provider does not "link" an outpatient encounter to an internal order.

• In this situation, first determine whether the order is an external or internal one.
  – If external, the use of a general Dx is acceptable.
  – If internal, it will be necessary to obtain the appropriate Dx code from the coder/provider.

• Acceptable general Dx codes for these circumstances are:
  – Radiology V72.5
  – Laboratory V72.6
  – Pharmacy Refill V68.1

FLs Required for Diagnosis/Provider Information

- FL 82 Attending Physician
- FL 83 Other Physician ID
- FL 84 Remarks
- FL 85 Provider Representative
- FL 86 Date

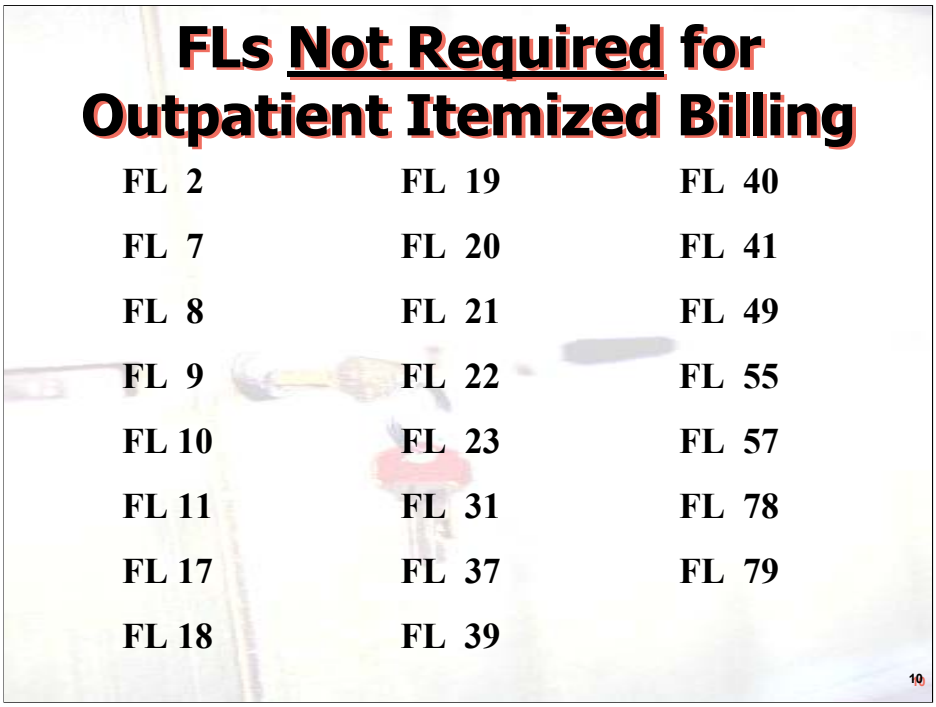


- **FL 82 -** is the required provider identification with credentials.

- **FL 83 -** is the required assisting provider identification with credentials.

- **FL 84 -** is used for any additional information that can aid in adjudicating the claim.

- **FLs 85-86 -** The signature or stamp of the provider of service or supplier or his/her representative and the date the form was signed should be completed. This area can also be used to indicate who the TPC manager is and that the bill has been reviewed.



- Information on this slide indicates that those FLs are not required for Outpatient Itemized Billing.

- Many of these FLs apply to inpatient services.

- For training purposes, please remember that all FLs that are not required are indicated with an **"X"** on the claim example.

Key Points

- **There will be multiple line items on the UB-92, with HCPCS/CPT-4s and associated rates, identifying outpatient surgery, clinical diagnostic lab, radiology, and other diagnostic services.**

- **Revenue codes will be listed on UB-92 (not the CMS-1500) and can be modified by the biller; each line item listed in FL 44 will have an associated revenue code.**

Proprietary 2002 "UB-92 Claim Form" Version 1.0 Standard Technology, Inc. Falls Church, VA

- Are there any questions?

UB-92 Claim Form Instructions

FL 1: Provider Name, Address & Telephone #, Required

DoD Format Requirements: **Required**
Enter the name of the provider, address and telephone numbers. They should be on four lines as follows:

Line 1	Provider name
Line 2	Street address or post office box number
Line 3	City, state, and zip code
Line 4	Area code, telephone number, fax number, and country code

FL 2: Unlabeled Field, Not Required

DoD Format Requirements: Not Required
Leave blank.

FL 3: Patient Control No., **Required**

DoD Format Requirements: Required
Enter the patient's account number that is assigned by the MTF's accounting system (TPOCS) to identify that particular patient. This account number is the same number as Item 26 on the HCFA 1500 claim form for the same episode of care/date of service.

FL 4: Type of Bill, **Required**

DoD Format Requirements: Required
Enter a three-digit code that indicates whether the bill type based on the following guidelines. The default type of bill will be 131 for outpatient services with the system capabilities to select other bill types when necessary.

First Digit	Second Digit	Third Digit
This digit identifies the type of facility.	This digit classifies the type of care being billed.	This digit indicates the sequence of the bill for a specific episode of care.
1XX Hospital	11X Hospital Inpatient (Including Medicare Part A)	XX0 Nonpayment/Zero Claim XX1 Admit-Through-Discharge Claim XX2 Interim—First Claim XX3 Interim—Continuing Claim XX4 Interim—Last Claim XX5 Late Charges Only Claim XX6 Adjustment of Prior Claim XX7 Replacement of Prior Claim XX8 Void/Cancel of a Prior Claim XX9 Reserved for National Assignment

UB-92 Claim Form Instructions

First Digit	Second Digit	Third Digit
	12X Hospital Inpatient (Medicare Part B Only)	XX0 Nonpayment/Zero Claim XX1 Admit-Through-Discharge Claim XX2 Interim—First Claim XX3 Interim—Continuing Claim XX4 Interim—Last Claim XX5 Late Charges Only Claim XX6 Adjustment of Prior Claim XX7 Replacement of Prior Claim XX8 Void/Cancel of a Prior Claim XX9 Reserved for National Assignment
	13X Hospital Outpatient	XX0 Nonpayment/Zero Claim XX1 Admit-Through-Discharge Claim XX2 Interim—First Claim XX3 Interim—Continuing Claim XX4 Interim—Last Claim XX5 Late Charges Only Claim XX6 Adjustment of Prior Claim XX7 Replacement of Prior Claim XX8 Void/Cancel of a Prior Claim XX9 Reserved for National Assignment
	14X Hospital Other	XX0 Nonpayment/Zero Claim XX1 Admit-Through-Discharge Claim XX2 Interim—First Claim XX3 Interim—Continuing Claim XX4 Interim—Last Claim XX5 Late Charges Only Claim XX6 Adjustment of Prior Claim XX7 Replacement of Prior Claim XX8 Void/Cancel of a Prior Claim XX9 Reserved for National Assignment
	18X Hospital Swing Beds	XX0 Nonpayment/Zero Claim XX1 Admit-Through-Discharge Claim XX2 Interim—First Claim XX3 Interim—Continuing Claim XX4 Interim—Last Claim XX5 Late Charges Only Claim XX6 Adjustment of Prior Claim XX7 Replacement of Prior Claim XX8 Void/Cancel of a Prior Claim XX9 Reserved for National Assignment

UB-92 Claim Form Instructions

FL 5: Fed. Tax No., **Required**

DoD Format Requirements: Required
Enter the Hospital/MTF's Federal Tax number that is assigned by the federal government for tax reporting purposes.

FL 6: Statement Covers Period, **Required**

DoD Format Requirements: Required
Enter the beginning and ending dates (CCYYMMDD) for the entire period reflected on the bill.

FL 7: Covered Days, Not Required

DoD Format Requirements: Not Required
For inpatient Medicare/Medicaid, enter the total number of days reported in FL 46. For outpatient claims, leave blank.

FL 8: Non-Covered Days, Not Required

DoD Format Requirements: Not Required
Leave blank.

FL 9: Coinsurance Days, Not Required

DoD Format Requirements: Not Required
Leave blank.

FL 10: Lifetime Reserve Days, Not Required

DoD Format Requirements: Not Required
Leave blank.

UB-92 Claim Form Instructions

FL 11: Unlabeled Field, Not Required

DoD Format Requirements: Not Required
Leave blank.

FL 12: Patient Name, **Required**

DoD Format Requirements: Required
Enter the patient's name (last name, first name and middle initial)

FL 13: Patient Address, **Required**

DoD Format Requirements: Required
Enter the full mailing address of the patient.

FL 14: Patient Birthdate, **Required**

DoD Format Requirements: Required
Enter the patient's date of birth (MMDDYYYY).

FL 15: Patient Sex, **Required**

DoD Format Requirements: Required
Enter the sex of the patient as recorded at the time of registration as an inpatient or outpatient or at the start of care. This field is one alphanumeric field (M, F, U [unknown]).

FL 16: Patient Marital Status, **Required**

DoD Format Requirements: Required
Enter the marital status of the patient as recorded at the time of registration as an inpatient or outpatient or at the start of care. If unknown, the field will default to 'U'.

S	single
M	married
D	divorced
W	widowed
X	legally separated
U	unknown

FL 17: Admission Date, Not Required

DoD Format Requirements: Not Required
Enter the date (MMDDCCYY) the patient was admitted to the provider as an inpatient, outpatient, or other start of care.

UB-92 Claim Form Instructions

FL 18: Admission Hour, Not Required

DoD Format Requirements: Not Required
Enter the hour (see below for format) during which the patient was admitted for inpatient or outpatient care.

00	12:00 (midnight) – 12:59 AM
01	01:00 – 01:59
02	02:00 – 02:59
03	03:00 – 03:59
04	04:00 – 04:59
05	05:00 – 05:59
06	06:00 – 06:59
07	07:00 – 07:59
08	08:00 – 08:59
09	09:00 – 09:59
10	10:00 – 10:59
11	11:00 – 11:59
12	12:00 – 12:59 PM
13	01:00 – 01:59
14	02:00 – 02:59
15	03:00 – 03:59
16	04:00 – 04:59
17	05:00 – 05:59
18	06:00 – 06:59
19	07:00 – 07:59
20	08:00 – 08:59
21	09:00 – 09:59
22	10:00 – 10:59
23	11:00 – 11:59
24	unknown

FL 19: Admission Type, Not Required

DoD Format Requirements:
Fill in this field for inpatient admission only according to the following codes:

1 Emergency (condition is severe, life-threatening or potentially disabling and requires immediate medical intervention)
2 Urgent (condition is such that patient requires immediate attention and is admitted to the first available and suitable accommodation)
3 Elective (condition permits time for medical services to be scheduled)
4 Newborn (this code is for a baby born within the facility)

UB-92 Claim Form Instructions

FL 20: Source of Admission, Not Required

DoD Format Requirements:
Enter in the numeral '2' (clinic referral) to indicate that the source of the admission either to inpatient or outpatient was the MTF.

FL 21: Discharge Hour, Not Required

DoD Format Requirements:
Enter the hour that the patient was discharged from inpatient care. See FL 18 for codes.

FL 22: Patient Status, **Required**

DoD Format Requirements:
Enter the correct code to indicate the patient's disposition as of the ending date of the service for the period of care reported.

01	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF
04	Discharged/transferred to ICF
05	Discharged/transferred to another type of institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advise or discontinued care
08	Discharged/transferred to home under care of home IV provider
09	Admitted as an inpatient to this hospital
10-19	Discharge to be defined at state level, if necessary
20	Expired (or did not recover – Christian Science Patient)
21-29	Expired to be defined at state level, if necessary
30	Still a patient
31-39	Still patient to be defined at state level, if necessary
40	Expired at home (for hospice care only)
41	Expired in a medical facility such as a hospital, SNF, ICF, or freestanding hospice (for hospice care only)
42	Expired, place unknown (for hospice care only)
43-49	Reserved for national assignment
50	Discharged to hospice – home
51	Discharged to hospice – medical facility
52-60	Reserved for national assignment
62-70	Reserved for national assignment
73-99	Reserved for national assignment

UB-92 Claim Form Instructions

FL 23: Medical/Health Record Number, Not Required

DoD Format Requirements: Not Required
Enter the patient's Medical Record Number (FMP/Sponsor SSN).

FL 24-30: Condition Codes, Conditional

DoD Format Requirements: Conditional
These fields contain codes utilized to identify conditions relating to the bill that may affect payer processing.

Insurance Codes

01 Military Service Related
02 Condition is Employment Related
03 Patient Covered by Insurance Not Reflected Here
04 Patient is HMO Enrollee
05 Lien Has Been Filed
06 ESRD Patient in First 18 [30] Months of Entitlement Covered by Employer Group Health Insurance
07 Treatment of Non-terminal Condition for Hospice Patient
08 Beneficiary Would Not Provide Information Concerning Other Insurance Coverage
09 Neither Patient Nor Spouse Is Employed
10 Patient and/or Spouse Is Employed but No EGHP Coverage Exists
11 Disabled Beneficiary, but No Large Group Health Plan (LGHP) Coverage
12-14 Reserved for Payer Use Only
15 Clean Claim Delayed in HCFA's Processing System
16 SNF Transition Exemption

Special Condition Codes

17 Patient Is Homeless
18 Maiden Name Retained
19 Child Retains Mother's Name
20 Beneficiary Requested Billing
21 Billing for Denial Notice
22 Patient on Multiple Drug Regimen
23 Home Care Giver Available
24 Home IV Patient Also Receiving HHA Services
25 Patient Is a Non-U.S. Resident
26 Veterans Affairs-Eligible Patient Chooses to Receive Services in Medicare-Certified Facility
27 Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test
28 Patient and/or Spouse's Employer Group Health Plan (EGHP) Is Secondary to Medicare

29 Disabled Beneficiary and/or Family Member's LGHP Is Secondary to Medicare
30 Reserved for National Assignment

Student Status
31 Patient Is Student (Full-Time Day)
32 Patient Is Student (Cooperative/Work Study Program)
33 Patient Is a Student (Full-Time Night)
34 Patient Is Student (Part-Time)
35 Reserved for National Assignment

Accommodation Codes
36 General Care Patient in a Special Unit
37 Ward Accommodation at Patient's Request
38 Semiprivate Room Not Available
39 Private Room Medically Necessary
40 Same-Day Transfer
41 Partial Hospitalization
42-45 Reserved for National Assignment

CHAMPUS Information Codes
46 Non-availability Statement on File
47 Reserved for CHAMPUS
48 Psychiatric Residential Treatment Centers (RTCs) for Children and Adolescents
49-54 Reserved for National Assignment

SNF Information
55 SNF Bed Not Available
56 Medical Appropriateness
57 SNF Readmission
58 Reserved for National Assignment
59 Terminated Medicare + Choice Organization Enrollee

Prospective Payment Codes
60 Day Outlier
61 Cost Outlier
62 Payer Code
63 Payer Only Code
64 Payer Only Code
65 Payer Only Code
66 Provider Does Not Wish Cost Outlier Payment
67 Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days
68 Beneficiary Elects to Use Lifetime Reserve (LTR) Days
69 Reserved for National Assignment

UB-92 Claim Form Instructions

Renal Dialysis Setting Codes

70 Self-Administered Erythropoietin (EPO)
71 Full Care in Unit
72 Self-Care in Unit
73 Self-Care Training
74 Home
75 Home—100 Percent Reimbursement
76 Backup In-Facility Dialysis

Other Codes

77 Provider Accepts or Is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full
78 New Coverage Not Implemented by HMO
79 CORF Services Provided Off-Site
80-99 Reserved for State Assignment

Special Program Indicator Codes

A0 CHAMPUS External Partnership Program
A1 EPSDT/CHAP
A2 Physically Handicapped Children's Program
A3 Special Federal Funding
A4 Family Planning
A5 Disability
A6 Vaccines/Medicare 100 Percent Payment
A7 Induced Abortion—Danger to Life
A8 Induced Abortion—Victim Rape/Incest
A9 Second Opinion Surgery
B0-B9 Reserved for National Assignment

PRO Approval Indicator Codes

C0 Reserved for National Assignment
C1 Approved as Billed
C2 Automatic Approval as Billed Based on Focused Review
C3 Partial Approval
C4 Admission/Services Denied
C5 Postpayment Review Applicable
C6 Admission/Preauthorization
C7 Extended Authorization
C8-C9 Reserved for National Assignment

Claim Change Reasons

D0 Changes to Services Dates
D1 Changes to Charges
D2 Changes in Revenue Codes/HCPCS
D3 Second or Subsequent Interim PPS Bill
D4 Change in Grouper Input

D5	Cancel to Correct HICN or Provider Identification Number
D6	Cancel Only to Repay a Duplicate or OIG Overpayment
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any Other Change
E0	Change in Patient Status
E1-L9	Reserved for National Assignment
M0	All Inclusive Rate for Outpatient Services (Payer Only Code)
M1	Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV)
M2	HHA Payment Significantly Exceeds Total Charges (Payer Only Code)
M3-M9	Reserved for Payer Assignment
N0-W9	Reserved for National Assignment
X0-Z9	Reserved for State Assignment

FL 31: Unlabeled Field, Not Required

DoD Format Requirements: Not Required
Leave blank.

FL 32-35: Occurrence Codes, Conditional

DoD Format Requirements: Conditional
These fields contain codes and associated dates defining a significant event relating to this bill that may affect payer processing.

Accident-Related Codes

01	Auto Accident
02	No-Fault Insurance Involved—Including Auto Accident/Other
03	Accident—Tort Liability
04	Accident—Employment Related
05	Other Accident
06	Crime Victim
07-08	Reserved for National Assignment

Medical Condition Codes

09	Start of Infertility Treatment Cycle
10	Last Menstrual Period
11	Onset of Symptoms/Illness
12	Date of Onset for a Chronically Dependent Individual (CDI)
13-16	Reserved for National Assignment

Insurance-Related Codes

17	Date Outpatient Occupational Therapy Plan Established or Last Reviewed
18	Date of Retirement of Patient/Beneficiary
19	Date of Retirement of Spouse

20 Guarantee of Payment Began
21 UR Notice Received
22 Date Active Care Ended
23 Reserved for National Assignment
24 Date Insurance Denied
25 Date Benefits Terminated by Primary Payer
26 Date SNF Bed Became Available
27 Date of Hospice Certification or Recertification
28 Date Comprehensive Outpatient Rehabilitation Facility (CORF) Plan Established or Last Reviewed
29 Date Outpatient Physical Therapy Plan Established or Last Reviewed
30 Date Outpatient Speech Pathology Plan Established or Last Reviewed
31 Date Beneficiary Notified of Intent to Bill (Accommodations)
32 Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)
33 First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP
34 Date of Election of Extended Care Services
35 Date Treatment Started for Physical Therapy
36 Date of Inpatient Hospital Discharge for Covered Transplant Patient
37 Date of Inpatient Hospital Discharge for Noncovered Transplant Patient
38 Date Treatment Started for Home IV Therapy
39 Date Discharged on a Continuous Course of IV Therapy

Service-Related Codes

40 Scheduled Date of Admission
41 Date of First Test for Preadmission Testing
42 Date of Discharge (Hospice Only)
43 Scheduled Date of Cancelled Surgery
44 Date Treatment Started for Occupational Therapy
45 Date Treatment Started for Speech Therapy
46 Date Treatment Started for Cardiac Rehabilitation
47-49 Payer Codes
50-69 Reserved for State Assignment
70-99 Reserved for Occurrence Span Codes
A0 Reserved for National Assignment
A1 Birth Date—Insured A
A2 Effective Date—Insured A Policy
A3 Benefits Exhausted
A4-A9 Reserved for National Assignment
B0 Reserved for National Assignment
B1 Birth Date—Insured B
B2 Effective Date—Insured B Policy
B3 Benefits Exhausted
B4-B9 Reserved for National Assignment
C0 Reserved for National Assignment
C1 Birth Date—Insured C

C2 Effective Date—Insured C Policy
C3 Benefits Exhausted
C4-C9 Reserved for National Assignment
D0-D9 Reserved for National Assignment
E0 Reserved for National Assignment
E1 Birth Date—Insured D
E2 Effective Date—Insured D Policy
E3 Benefits Exhausted
E4-E9 Reserved for National Assignment
F0 Reserved for National Assignment
F1 Birth Date—Insured E
F2 Effective Date—Insured E Policy
F3 Benefits Exhausted
F4-F9 Reserved for National Assignment
G0 Reserved for National Assignment
G1 Birth Date—Insured F
G2 Effective Date—Insured F Policy
G3 Benefits Exhausted
G4-G9 Reserved for National Assignment
H0-I9 Reserved for National Assignment
J0-L9 Reserved for State Assignment
M0-Z9 See Definitions Under Occurrence Span Codes (FL 36)

FL 36: Occurrence Span Codes and Dates, Conditional

DoD Format Requirements: Conditional
This field contains a code and the related date that identify an event that relate to the payment of the claim.

70 Qualifying Stay Dates (For SNF Use Only)
70 Nonutilization Dates (For Payer Use Only on Hospital Bills)
71 Prior Stay Dates
72 First/Last Visit
73 Benefit Eligibility Period
74 Noncovered Level of Care/LOA
75 SNF Level of Care
76 Patient Liability
77 Provider Liability Period
78 SNF Prior Stay Dates
79 Payer Code
80-99 Reserved for State Assignment
M0 PRO/UR Approved Stay Dates
M1 Provider Liability—No Utilization
M2-W9 Reserved for National Assignment
X0-Z9 Reserved for State Assignment

UB-92 Claim Form Instructions

FL 37: Internal Control Number (ICN)/Document Control Number (DCN), Not Required

DoD Format Requirements: Not required
Leave blank.

FL 38: Responsible Party Name and Address, **Required**

DoD Format Requirements: Required
Enter the name and address of the party responsible for the bill.

FL 39-41: Value Codes and Amounts, Conditional

DoD Format Requirements: Required, if applicable
These fields contain codes and the related dollar amount identifying monetary data necessary to process this claim. Space for up to 12 value codes and associated amounts can be identified in FL 39, 40, 41 (a, b, c, d). Data entered into these FL will represent any services provided by the MTF which are being billed on a separate claim form other than the current UB-92 claim form. This field will be automatically populated with the value code '05' to indicate that the professional components are included in the charges but are also billed separately to the carrier. The associated monetary value will then be deducted from the total covered charges reported on the UB-92 claim. The total amount of these services will not be reflected in Est. Amt Due field (FL-55), on the UB-92 form, but will in most cases be reflected on the HCFA 1500 claim form.

01	Most Common Semiprivate Room Rate
02	Hospital Has No Semiprivate Rooms
03	Reserved for National Assignment
04	Inpatient Professional Component Charges that Are Combined Billed
05	Professional Component Included in Charges and Also Billed Separately to Carrier
06	Medicare Blood Deductible
07	Reserved for National Assignment
08	Medicare Lifetime Reserve Amount in the First Calendar Year
09	Medicare Coinsurance Amount in the First Calendar Year
10	Medicare Lifetime Reserve Amount in the Second Calendar Year
11	Medicare Coinsurance Amount for Second Calendar Year
12	Working Aged Beneficiary/Spouse with EGHP
13	ESRD Beneficiary in a Medicare Coordination Period with an EGHP
14	No-Fault, Including Auto/Other
15	Workers Compensation
16	Public Health Service (PHS) or Other Federal Agency
17	Outlier Amount
18	Disproportionate Share Amount
19	Indirect Medical Education Amount
20	Total PPS Capital Payment Amount
21	Catastrophic

22 Surplus
23 Recurring Monthly Income
24 Medicaid Rate Code
25-29 Reserved for National Assignment--Medicaid
30 Preadmission Testing
31 Patient Liability Amount
32-36 Reserved for National Assignment
37 Pints of Blood Furnished
38 Blood Deductible Pints
39 Pints of Blood Replaced
40 New Coverage Not Implemented by HMO (for Inpatient Claims Only)
41 Black Lung
42 Veterans Affairs
43 Disabled Beneficiary Under Age 65 with LGHP
44 Amount Provider Agreed to Accept from the Primary Insurer When this Amount Is Less than Total Charges, but Greater than the Primary Insurer's Payment
45 Accident Hour
46 Number of Grace Days
47 Any Liability Insurance
48 Hemoglobin Reading
49 Hematocrit Reading
50 Physical Therapy Visits
51 Occupational Therapy Visits
52 Speech Therapy Visits
53 Cardiac Rehabilitation Visits
54-55 Reserved for National Assignment

Home-Health-Specific

56 Skilled Nurse—Home Visit Hours (HHA Only)
57 Home Health Aide—Home Visit Hours (HHA Only)
58 Arterial Blood Gas (PO2/PA2)
59 Oxygen Saturation (O2 Sat/Oximetry)
60 HHA Branch MSA
61 Location Where Service Is Furnished (HHA and Hospice)
62-66 Reserved for National Assignment
67 Peritoneal Dialysis
68 EPO--Drug
70 Interest Amount
71 Funding of ESRD Networks
72 Flat Rate Surgery Charge
73 Drug Deductible
74 Drug Coinsurance
75 Gramm-Rudman-Hollings
76 Providers Interim Rate
77-79 Payer Codes

80-99 Reserved for State Assignment
A0 Reserved for National Assignment
A1 Deductible Payer A
A2 Coinsurance Payer A
A3 Estimated Responsibility Payer A
A4 Covered Self-Administrable Drugs—Emergency
A5 Covered Self-Administrable Drugs—Not Self-Administrable in Form and Situation Furnished to Patient
A6 Covered Self-Administrable Drugs—Diagnostic Study and Other
A7-AZ Reserved for National Assignment
B0 Reserved for National Assignment
B1 Deductible Payer B
B2 Coinsurance Payer B
B3 Estimated Responsibility Payer B
B4-BZ Reserved for National Assignment
C0 Reserved for National Assignment
C1 Deductible Payer C
C2 Coinsurance Payer C
C3 Estimated Responsibility Payer C
C4-CZ Reserved for National Assignment
D0-D2 Reserved for National Assignment
D3 Estimated Responsibility Patient
D4-DZ Reserved for National Assignment
E0 Reserved for National Assignment
E1 Deductible Payer D
E2 Coinsurance Payer D
E3 Estimated Responsibility Payer D
E4-EZ Reserved for National Assignment
F0 Reserved for National Assignment
F1 Deductible Payer E
F2 Coinsurance Payer E
F3 Estimated Responsibility Payer E
F4-FZ Reserved for National Assignment
G0 Reserved for National Assignment
G1 Deductible Payer F
G2 Coinsurance Payer F
G3 Estimated Responsibility Payer F
G4-GZ Reserved for National Assignment
H0-YZ Reserved for National Assignment
X0-ZZ Reserved for National Assignment

FL 42: Revenue Code, **Required**

DoD Format Requirements: Required
Enter the numeric code corresponding to identify a specific accommodation and/or ancillary service performed. Refer to the UB-92 manual for a listing of revenue codes and their

definitions. In most cases, the revenue code will reflect the clinic visit charge. The system capability to enter and print duplicate revenue codes is required when billing payer organizations. Each revenue code will be listed in FL-42 and the corresponding CPT-4 or HCPCS code will be associated in FL-44 to differentiate the type of services which were provided and therefor provide verification that the services billed were not considered duplicates.

In all cases, revenue code 001 must be on the last line, reflecting the claim's total charges.

FL 43 Revenue Description, **Required**

*DoD Format Requirements:*Required
This field will be automatically filled in with the description of the CPT Code or drug listed in FL 44.

FL 44: HCPCS/Rates, **Required**

DoD Format Requirements: Required
Enter the accommodation rate for inpatient bills and HCPCS applicable to ancillary services for outpatient bills. This field is automatically populated with the correct rate.

FL 45: Service Date, **Required**

DoD Format Requirements: Required
Enter the date the service was provided.

FL 46: Unit of Service, **Required**

DoD Format Requirements: Required
Enter the total number of covered accommodation days, units or visits. In most cases, the units will be the numeral one.

FL 47: Total Charges, **Required**

DoD Format Requirements: Required
Enter the total charges reflected on this claim for the statement covers period (FL 6). This field will be automatically calculated and populated.

FL 48: Non-Covered Charges, Optional

DoD Format Requirements:
Leave blank.

FL 49: Unlabeled Field, Not Required

DoD Format Requirements: Not Required

Leave blank.

FL 50: Payer, Required

DoD Format Requirements: **Required**
Enter the name and, if required, the number identifying each payer organization from which the provider might expect some payment for the bill. Line 50A is for the primary payer. Line 50B is used for the secondary provider, if applicable.

FL 51: Provider Number, **Required**

DoD Format Requirements: Required
Enter the provider number which is assigned by the insurance carrier/payer organization listed in FL 50.

FL 52: Release of Information Certification Indicator, **Required**

DoD Format Requirements: Required
Enter Y to indicate that the MTF has on file a signed statement permitting them to release data to other organizations in order to adjudicate the claim. TPOCS will default to 'Y'.

FL 53: Assignment of Benefit, **Required**

DoD Format Requirements: Required
A "Y" is indicated to confirm that the MTF has a signed form authorizing the third party payer to pay them. TPOCS will default to 'Y'.

FL 54: Prior Payment – Payers and Patient, Conditional

DoD Format Requirements:
Enter the amount the MTF has received toward payment of this bill prior to the billing date.

FL 55: Estimated Amount Due, Not Required

DoD Format Requirements: Not Required
Leave blank.

FL 56: Unlabeled field, Not Required

DoD Format Requirements: Not Required
Leave blank.

FL 57: Unlabeled field, Not Required

DoD Format Requirements: Not Required
Leave blank.

UB-92 Claim Form Instructions

FL 58: Insured's Name, **Required**

DoD Format Requirements: Required
Enter the name of the patient or insured individual in whose name the insurance is issued as qualified by the payer organization listed in FL 50.

FL 59: Patient' Relationship to Insured, **Required**

DoD Format Requirements: Required
Enter the code that indicates the relationship of the patient to the insured individuals identified in FL 58.

01	patient is the insured
02	spouse
03	natural child/insured has financial responsibility
04	natural child/insured does not have financial responsibility
05	stepchild
06	foster child
07	ward of the court
08	employee
09	unknown
10	handicapped dependent
11	organ donor
12	cadaver donor
13	grandchild
14	niece/nephew
15	injured plaintiff
16	sponsored dependent
17	minor dependent of a minor dependent
18	parent
19	grandparent
20	life partner
21-99	reserved for national assignment

FL 60: Certificate/SSN/Health Insurance Claim/Identification Number, **Required**

DoD Format Requirements: Required
Enter the insured's identification number assigned by the payer organization.

FL 61: Group Name, Conditional

DoD Format Requirements: Conditional
Enter the name of the group or plan through which the health insurance coverage is provided to the insured.

UB-92 Claim Form Instructions

FL 62: Insurance Group Number, Conditional

*DoD Format Requirements:*Conditional
Enter the identification number, control number, or the code that is assigned by the insurance company to identify the group under which the individual is covered.

FL 63: Treatment Authorization Codes, Conditional

DoD Format Requirements: Conditional
Enter the number or other indicator that designates that the treatment covered by this claim has been authorized by the payer indicated in FL 50 for all approved admissions or services.

FL 64: Employment, Not Required/Optional

DoD Format Requirements:
Enter the code that defines the employment status of the insured individual identified in FL 58.

1	employed full-time
2	employed part-time
3	not employed
4	self-employed
5	retired
6	on active military duty
7-8	reserved for national assignment
9	unknown

FL 65: Employer Name, Not Required/Optional

DoD Format Requirements:
Enter the name of the employer that provides (or may provide) health care coverage for the insured individual identified in FL 58.

FL 66: Employer Location, Not Required/Optional

DoD Format Requirements:
Enter the specific location of the employer of the insured individual identified in FL 58. The location can be a specific city, plant, or other location.

FL 67: Principal Diagnosis Code, **Required**

DoD Format Requirements: Required
Enter the ICD-9-CM diagnosis code, including the fourth and fifth digits, if applicable, that describes the principal diagnosis (the condition established after study to be chiefly responsible for causing the use of services).

FL 68-75: Other Diagnosis Codes, **Conditional**

DoD Format Requirements:
Enter the ICD-9-CM diagnosis codes, including the fourth and fifth digits, if applicable, corresponding to the patient's additional conditions that coexist a the time of treatment or develop subsequently and which have an effect on the treatment received of length of stay.

FL 76: Admitting Diagnosis, **Required**

DoD Format Requirements: Required.
Enter the ICD-9-CM diagnosis code, including the fourth and fifth digits when appropriate, describing the patient's diagnosis or reason for visit at the time of admission or outpatient registration. This is considered the field for the "Chief Complaint".

FL 77: E Code, Conditional

*DoD Format Requirements:*Conditional
Report an E code whenever there is a diagnosis of an injury, poisoning or other adverse effect.

FL 78: Unlabeled field, Not Required

DoD Format Requirements: Not required.
Leave blank.

FL 79: Procedure Coding Method Used, Not Required

DoD Format Requirements: Not required
Leave blank.

FL 80: Principal Procedure Code and Date, **Required**

DoD Format Requirements:
Enter the principal procedure is a CPT/HCPCS code for outpatient services (ICD-9-CM-inpatient services) performed during the period covered by this bill and the date on which the principal procedure described on the claim was performed.

FL 81: Other Procedure Codes and Date, **Conditional**

DoD Format Requirements:
Enter other ICD-9-CM codes to identify significant procedures performed during the billing period, other than the principal procedure, and the corresponding dates on which the procedures were performed.

FL 82: Attending Physician ID, **Required**

UB-92 Claim Form Instructions

DoD Format Requirements:
Enter the name of the licensed physician who has the primary responsibility for the patient's medical care and treatment and/or who normally would be expected to certify and re-certify the medical necessity of the services rendered. It is now required that the provider be identified with their credentials (MD, LPN, PA, RN, etc.) System should include the provider's credentials following the name. The system will automatically fill in with OTH000 until NUBC approval of DoD000.

FL 83: Other Physician ID, Required, if applicable

DoD Format Requirements:
Enter the name of other licensed physicians other than attending physician, that provided care to the patient.

FL 84: Remarks, Required, if applicable

DoD Format Requirements:
Enter any information related to specific third-party payer needs. Provide any additional information that is necessary to adjudicate the claim or otherwise fulfill the payer's reporting requirements.

FL 85: Provider Representative, **Required**

DoD Format Requirements:
The field requires a signature on face of the claim in conformance with certification on the back of the bill. In some cases, a stamp and faxed signature is acceptable.

FL 86: Date Bill Submitted, **Required**

DoD Format Requirements:
Enter the date that the claim was submitted to the payer.

CMS 1450/UB-92 HANDOUT
Quick Reference Sheet

FL 1	Provider Name, Address & Telephone #	Required	
FL 3	Patient Control No.	Required	
FL 4	Type of Bill	Required	
FL 5	Federal Tax #	Required	
FL 6	Coverage Period	Required	
FL 12	Patient Name	Required	
FL 13	Patient Address	Required	
FL 14	Patient Birthdate	Required	
FL 15	Sex	Required	
FL 16	Marital Status	Required	
FL 22	Patient Status	Required	
FL 24-30	Condition Codes	Conditional	
FL 32-35	Occurrence Codes	Conditional	
FL 36	Occurrence Span	Conditional	
FL 38	Responsible Party Name & Address	Required	
FL 39-41	Value Codes and Amounts	Conditional	
FL 42	Revenue Code	Required	
FL 43	Description	Required	
FL 44	HCPCS/Rates	Required	
FL 45	Service Date	Required	
FL 46	Service Units	Required	
FL 47	Total Charges	Required	
FL 48	Non-Covered Charges	Not Required	Optional*
FL 50	Payer Identification	Required	
FL 51	Provider Number	Required	
FL 52	Release of Information	Required	
FL 53	Assignment of Benefits	Required	
FL 54	Prior Payments	Conditional	
FL 58	Insured (Policy Holder) Name	Required	
FL 59	Patient's Relationship to Insured	Required	
FL 60	Certificate/SSN/Health Insurance Claim ID#	Required	
FL 61	Group Name	Conditional	
FL 62	Insurance Group No.	Conditional	
FL 63	Treatment Authorization Code (Pre-Cert)	Conditional	
FL 64	Employment	Not Required	Optional*
FL 65	Employer Name	Not Required	Optional*
FL 66	Employer Location	Not Required	Optional*
FL 67	Principal Diagnosis Code	Required	
FL 68-75	Other Diagnosis Code(s)	Conditional	
FL 76	Admitting Diagnosis (Chief Complaint)	Required	
FL 77	External Causes Codes (E Codes)	Conditional	
FL 80	Principal Procedure	Required	
FL 81	Other Procedure Code(s) and Dates	Conditional	
FL 82	Attending Physician	Required	
FL 83-84	Other Physician(s)	Required	If Applicable
FL 85	Provider Representative	Required	
FL 86	Date Claim Submitted	Required	

* Optional means that those Form Locators (FLs) are not required but can be populated based on your facility's business practices. For training purposes, all FLs that are not required are indicated with an "X" on the claim example.